CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

KP 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

5

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. Establish retention period for records which are accumulating daily.	B. Dispose of present accumulation, no additional accumulation anticipated.	C. Microfilm and destroy originals.	D. Microfilm and retain originals for length of time indicated below.
☐	☐	☐	☒

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval — Robert E. Farber M.D. — Title: Commissioner of Health — 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐	☒	☐

REMARKS:

C P Force — Records Management Officer — 3/29/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

G55951 | BALTIMORE CITY HEALTH DEPARTMENT | G55951 Registered No.

CERTIFICATE OF DEATH 46M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered or the word or phrase that will correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 N. Stricker
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N. Stricker (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Pierce
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31 - 1891

8. AGE: Years	Months	Days	If less than one day
56	4	9 10	hr. min.

9. Birthplace Halifax N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Pierce
13. Birthplace N. C.

MOTHER
14. Maiden Name Della ?
15. Birthplace N. C.

16 (a) Informant Ruth Holliday
(b) Address 922 N. Stricker

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-14-47 (month) (day) (year)
(c) Cemetery or crematory Epps
Location Weldon N. C.

18 (a) Funeral director Samuel W. Sullivan & Son
(b) Address 1011 N. Arlington Ave

19 (a) (Date received by registrar) (b) Registrar

OCT 16 1947
S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1947, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8 1947 to 10/10 1947 and that I last saw h[illegible] alive on 10/9 1947.

Immediate cause of death	Duration
(a) Carcinoma Gl.	
Due to (b) Fracture	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. T. Hatcher M.D.
Address 1215 Preston Date signed 10/11/47

X

G55952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G55952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light Street
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 63

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (30) (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 E. Hill St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Grace E Folderauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Rodney Folderauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1884

8. AGE: Years	Months	Days	If less than one day
62 63	9	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Jones
13. Birthplace Matthews Co. Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Agnes M. Folderauer
(b) Address 502 E Barney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem
Location Glen Burnie

18 (a) Funeral director Charles F. Weil
(b) Address 1501 W. Fort Ave

19 Oct 12 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1947, at 7.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1947 to Oct 9 1947, and that I last saw HER alive on Oct 9 1947

	Duration
Immediate cause of death ACUTE CARDIO RESPIRATORY FAILURE	
Due to IRREVERSIBLE CONGESTIVE HEART FAILURE	
Due to HYPERTENSIVE CARDIOVASCULAR DISEASE	
Other Conditions HYPOSTATIC PNEUMONIA (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William B. Cooper Jr. M. D.
Address SOUTH BALTO. GEN HOSP Date signed 10/9/47

VS 150

G55953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55953 Registered No.

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Everyone of information must be given. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 N. Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 304 N. Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Letitia Burgess Bell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Lorenza

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1866

8. AGE: Years 81 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Burgess
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eliza Beck
15. Birthplace Balto. Md.

16 (a) Informant Page Bell
(b) Address 304 N. Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13 1947 (month) (day) (year)
(c) Cemetery or crematory Ellsworth
Location Westminster Md.

18 (a) Funeral director Mrs. George H. Mullen
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

Oct 12 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9-47 1947, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1947 to 10-9 1947 and that I last saw her alive on 10-8 1947.

Immediate cause of death
Due to Hypostatic Pneumonia
Due to Renal Disease
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Butler M. D.
Address 837 Eutaw Place Date signed 10/11/47

VS 456

Patrick
G55954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 99

G55954
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Every line must be filled. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 Rob St.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 Rob St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Paul Patrick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Catherine Patrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20 1905

8. AGE: Years	Months	Days	If less than one day
42	5	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Asst Sales Mgr.
11. Industry or business

FATHER 12. Name Joseph Patrick
13. Birthplace ?

MOTHER 14. Maiden Name Isabelle Magraw
15. Birthplace Md.

16 (a) Informant Mrs Catherine Patrick
(b) Address 2024 Rob St.

17 (a) Burial (b) Date thereof 10-13-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto Md

18 (a) Funeral director Leonard J. Cook
(b) Address 5305 Harford Rd

19 (a) Oct 10 1947 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1947 at 2:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Oct. 10 1947 and that I last saw h[illegible] alive on Oct. 10 1947.

Immediate cause of death	Duration
Periarteritis Nodosa	18 months
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Fiesting M. D.
Address 11 E. Chase St. Date signed 10/12/47

X

~~755955~~ BALTIMORE CITY HEALTH DEPARTMENT 755955
Registered No.

CERTIFICATE OF DEATH 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be entered. If correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Henry Thornton
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colo | 6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Mary
6 (c) If alive, give age 186 years
7. Birth date of deceased (mo., day, yr.) May 29 1862
8. AGE: Years 85 | Months 4 | Days 29 | If less than one day: hr. min.
9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

MOTHER / FATHER
12. Name Henry Thornton
13. Birthplace Va
14. Maiden Name Martha Wyatt
15. Birthplace Va.

16 (a) Informant Mrs. Daniel Ringgold
(b) Address 925 Harlem Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.
18 (a) Funeral director Mrs. Nerget K. Hollingsworth
(b) Address 1631 Druid Hill Ave.
19 (a) OCT 9 1947 (b) Registrar Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9/47 19 2:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 6/31/47 to 10/8/47, and that I last saw him alive on 10/4/47
Immediate cause of death Acute Pancreohymorrhagic Pancreatitis
Due to Cyanosis
Due to
Other Conditions Hypertension Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury
23. Signature H. L. Barksdale M. D.
Address 524 ½ Carey St Date signed

55956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166 Registered No. 55956

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Do not write above or below the lines. Be sure to write the causes of death clearly and legibly. Give the exact place of death and full name of deceased. If not in a hospital or institution, give residence instead of street address. The space for "Length of stay" should be filled in whether the deceased was a resident or not. If the deceased was married, widowed, or divorced, the name of husband or wife should be given. The certificate must be filled in, signed, and returned to the funeral director or person acting as such, who will file it with the local registrar. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Massachusetts County
(c) City or town Quincy (If outside city or town limits, write RURAL and give town)
(d) Street No. Rhoda Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Malcolm Mayo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1898

8. AGE: Years	Months	Days	If less than one day
49	2	13	hr. min.

9. Birthplace Brockton, Mass. (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business Merchant Marine

FATHER
12. Name Anthony E. Mayo
13. Birthplace Provincetown, Mass.

MOTHER
14. Maiden Name Mary Tighe
15. Birthplace Ireland

16 (a) Informant Kenneth B. F. Mayo
(b) Address 31 Frost Ave. Brockton, Mass.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Melrose
Location Brockton, Mass.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 OCT 13 1947 (Date rec'd by registrar) (b) Huntington Ave, Mass. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1947, at 4:15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-11-47 at A. M.
(b) Where did injury occur? 713 W. Fayette Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Handgun - (Shot in head)

23. Signature Earl L. Virgin M.D. Medical Examiner.
Date signed

G55957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 783a

Registered No. G55957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Virginia (b) County Randolph
(c) City or town Elkins (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arlan W. Berry (ARLAN WILLIAM BERRY)
3 (b) If veteran, name war W.W. II
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Susan Berry
6 (c) If alive, give age 30 years
7. Birth date of deceased (mo., day, yr.) Dec 23, 1909
8. AGE: Years 37 Months 9 Days 19 If less than one day hr. min.
9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business

FATHER
12. Name Andrew W. Berry
13. Birthplace West Virginia

MOTHER
14. Maiden Name Anna May Zinn
15. Birthplace West Virginia

16 (a) Informant Mrs. Susan Berry (wife)
(b) Address Elkins - W. Va.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-15-47 (month) (day) (year)
(c) Cemetery or crematory Farmsworth
Location Gilmer Co. W. Va.
18 (a) Funeral director Stewart Morrison
(b) Address 108 W Main St.
19 (a) OCT 13 1947 (Date rec'd by registrar) (b) Huntington, W. Va. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1947, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1947, to Oct 12 1947, and that I last saw him alive on Oct 12 1947.

Immediate cause of death Subarachnoid hemorrhage — Duration 12 Days

Due to Possible rupture of Cerebral aneurysm — Duration Uncertain

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy Massive hemorrhage - base of brain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry V. Chase M. D.
Address Mercy Hospital Date signed 10/13/47

VS 180

G55958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46H

Registered No. G55958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwood & Greene
(c) Hospital or institution: State Univ. Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Upperco
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joel W. Davidson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Laura Elwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30 1872

8. AGE: Years	Months	Days	If less than one day
75	1	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name John Wesley Davidson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Allgire
15. Birthplace Md.

16 (a) Informant Newton Davidson
(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15-47 (month) (day) (year)
(c) Cemetery or crematory Hurley
Location Carroll Co

18 (a) Funeral director Edward Tipton
(b) Address Hampstead Md.

OCT 13 1947 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1947 at 10:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29 1947 to 10/12 1947 and that I last saw him alive on 10/12 1947.

Immediate cause of death	Duration
Cord Resp Collapse	
Due to Carcinomatosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/3
Major findings of operation: Acd. Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Taylor M. D.
Address Edwood & Greene Date signed 10/13/47

VS 150

G55959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓56 B

Registered No. G55959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1534 N. Gilmer St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Reed

3 (b) If veteran, name war

3 (c) Social Security Account No. 20-09-2984

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Heneny Reed

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 5-30-93

8. AGE: Years 54 | Months 4 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name John Barnett
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Jackson
15. Birthplace Virginia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14-1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn M. Park
Location Arbutus

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St. Hunting Town Williamsport, Md.

19 OCT 13 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1947 at 9 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1947 to Oct. 10 1947 and that I last saw h[illegible] alive on Oct. 10 1947

Immediate cause of death [redacted] Pulmonary embolism — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/1/47

Major findings of operation: Myomata uteri. Adenomatous polyps

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Gutschall Jr. M.D.
Address Johns Hopkins Hosp. Date signed 10/10/47

VS 150

1110

G55960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87E

Registered No. G55960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Arunah Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Arunah Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marqueritte E. Kramer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Femal	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 - 1901

8. AGE: Years	Months	Days	If less than one day
46	3	3	hr. min.

9. Birthplace Carlisle Pa. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles M. Kramer
13. Birthplace Frederick Co.

MOTHER
14. Maiden Name Anna E. Baker
15. Birthplace Frederick Co.

16 (a) Informant Mrs. Charles M. Kramer
(b) Address 2304 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date (month) (day) (year) Oct. 13-47
(c) Cemetery or crematory Lakewood
Location Wilmington, Del.

18 (a) Funeral director Elizabeth Hark Sons
(b) Address 115 E. West St.

19 (a) [illegible] Kathryn Williams M.D. Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10th 1947, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946, to October 10 1947, and that I last saw h[illegible] alive on October 9 1947.

Immediate cause of death
Cerebral hemorrhage — Duration 3 days

Due to Cerebral spastic infantile paralysis. — 46 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Nature of injury
21. Signature W. Michel M. D.
Address 2304 Edmondson Ave Date signed Oct. 11/47

G55961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55961 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 Woodland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [illegible] BUBA

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/27/21

8. AGE: Years 26 | Months 2 | Days [illegible] | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Ship yard

FATHER
12. Name William Arkins
13. Birthplace Pa.

MOTHER
14. Maiden Name Anna Christ
15. Birthplace Pa.

16 (a) Informant John Zang
(b) Address 3814 Bank Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave, Ext.

18 (a) Funeral director Lilly & Zeltenden
(b) Address 403 S. Wolfe Street

19 OCT 13 1947 (Date rec'd by registrar) (Signature) Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use the certificate of death clearly and legibly. correct age is especially important. Physicians: please write

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1947, at 5.50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions Fatty Degeneration of Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil A. Ryan, M.D.
Medical Examiner.
Date signed 10-12-47

G55962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

Registered No. G55962

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1604 N. Durham St
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 N. Durham St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Joseph Roth ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) UNKNOWN

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business —

FATHER
12. Name FRANCIS ROTH
13. Birthplace MD.

MOTHER
14. Maiden Name HENRIETTA BUSH
15. Birthplace MD.

16 (a) Informant SOPHIA BROWN - SISTER
(b) Address 1604 N. DURHAM ST.

17 (a) BURIAL (b) Date thereof 10-15-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL RD.

18 (a) Funeral director LILLY & ZEILER INC.
(b) Address 403 S. WOLFE ST.

19 (a) OCT 13 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12, 1947, at 5 AM

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 10/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be filled in. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

55963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

Registered 55963

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4303 Ridgewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4303 Ridgewood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES McDAIRMANT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widowed

6 (b) Name of husband Alexander H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) F-6 16-1873

8. AGE: Years 74 | Months 7 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Barr

13. Birthplace Germany

MOTHER 14. Maiden Name Un Known

15. Birthplace "

16 (a) Informant John Mc Dairmant

(b) Address 4303 Ridgewood Ave

17 (a) Cremation (b) Date thereof 10/14/47
~~Burial~~, cremation, ~~or removal~~ (month) (day) (year)

(c) ~~Cemetery or crematory~~ Green Mount

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 121 St. Pauls St.

19 OCT 13 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11/47 19 ..... at 5:10 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/11/47 3 PM
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury turned on gas burners

23. Signature John R. Fisher M.D.
Medical Examiner.
Date signed 10/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 151

55964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C55964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 N. Gay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard N. Blight, Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of ~~husband~~ or wife: Cora Blight

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 2, 1867

8. AGE: Years 80 | Months 4 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Gas & Elec Co.

FATHER
12. Name Robert Blight
13. Birthplace England

MOTHER
14. Maiden Name Julia Klein
15. Birthplace Md

16 (a) Informant Howard N. Blight, Jr.
(b) Address 4914 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore
Location North Ave & Rose St

18 (a) Funeral director Frank W. Seitz
(b) Address 814 West 36 St

19 (a) OCT 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1947, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to 10/11 1947 and that I last saw ~~him~~ alive on 10/11 1947

Immediate cause of death Coronary Thrombosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hyman Polley M. D.
Address 570 S Hanover St Date signed 10/13/47

G55965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G55965

GL. 96981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals 1-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Fait AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Napieralski

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Stella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan -8 -1893

8. AGE: Years	Months	Days	If less than one day
54	9	2	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Willian Napieralski
13. Birthplace Poland
14. Maiden Name Lucy Lenca
15. Birthplace Poland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14 1947 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J Duda
(b) Address 2829 Hudson St.

19 (a) Date rec'd 1947 Huntington Williams M.D. (Registrar)

DCP 19 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 - 1947, at 11.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 - 1945 to Oct. 10 1947, and that I last saw him alive on Oct. 10 1947.

Immediate cause of death Tuberculosis of Lungs Far advanced — Duration 30 mo+

Due to

Due to

Other Conditions Metastatic Abscess of Muscle of Right Hand — Duration 18 mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dwight W. Paulson M. D.
Address Balt City Hosp Date signed 10-10-47

VS 150

X

055966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 055966

KROSTAR 166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Krostar

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 52 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: STORE KEEPER

11. Industry or business

FATHER
12. Name: Jacob
13. Birthplace: Russia

MOTHER
14. Maiden Name: Fannig
15. Birthplace: Russia

16 (a) Informant: Lena Krostar
(b) Address: 2219 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-47 (month) (day) (year)

(c) Cemetery or crematory: Hebrew Mt Carmel
Location

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2100 Eutaw Place

19 OCT 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 11, 1947 at 7:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet Wound of Chest involving heart and lungs -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/11/47 at 7:20 P.M.
(b) Where did injury occur? 1130 Cathedral St Balto
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury: Firearm

23. Signature: Earl L. Royer M.D. Medical Examiner
Date signed 10-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Use "None" or "Unknown" where necessary. Do not use ditto marks. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G55967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55967 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 139 W Meadow Road R.R.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Buxton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: JESSIE M.

6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1867

8. AGE: Years: 80 | Months: - | Days: -1 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Thomas Buxton
13. Birthplace Md.

MOTHER
14. Maiden Name Brengle
15. Birthplace Pa.

16 (a) Informant Thomas Buxton
(b) Address 605 E. Randal St

17 (a) Burial (b) Date thereof 10/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Windsor Mill Rd

18 (a) Funeral director John F. Dempsey Inc
(b) Address 714 Light St

OCT 13 1947 (Date rec'd by registrar) (Signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1947, at 1:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 25 1947 to Oct 11 1947, and that I last saw him alive on Oct 11 1947.

Immediate cause of death	Duration
Myocardial infarction	3 weeks
due to coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M.D.
Address South Balto Gen Hosp Date signed Oct 14 1947

VS 150

G55968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G55968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2424 Woodbrook ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 Woodbrook ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary B. Peace

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Lonnie Peace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1882

8. AGE: Years 65 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Wilmer Johnson
13. Birthplace md

MOTHER 14. Maiden Name Katherine Barrett
15. Birthplace md

16 (a) Informant Lonnie Peace
(b) Address 2424 Woodbrook ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-47 (month) (day) (year)
(c) Cemetery or crematory Forest Hill md
Location md

18 (a) Funeral director George D. Kelson
(b) Address 1313 Pressman St

19 OCT 13 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1947, at 1.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1/47 19..., to Oct 9 1947.
and that I last saw h[er] alive on Oct 9 1947.

Immediate cause of death Acute Cardiac Decompensation — Duration

Due to Ch. Arteriosclerosis

Due to Ch. Myocarditis

Other Conditions Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ch. Homateni M. D.
Address 733 Argyle St Date signed 10/14/47

X

C55969

423954

BALTIMORE CITY HEALTH DEPARTMENT
107 CERTIFICATE OF DEATH 48a

Registered No. C55969

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 Cumberland, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Hardy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	married

6 (b) Name of husband or wife William Hardy

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 2-15-06

8. AGE: Years	Months	Days	If less than one day
39	7	24	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Moses Macey
13. Birthplace Md.

MOTHER
14. Maiden Name Isabel Mitchell
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10/15/47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Catonsville
Location Md.

18 (a) Funeral director Chas. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) OCT 13 1947 (b) Huntington for Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. - 11 - 1947 at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5- 1947 to 10-11- 1947 and that I last saw h alive on 10-11- 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Carcinoma metastases	
Due to Carcinoma cervix	
Other Conditions Anemia	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos. Mitchell M.D.
Address Johns Hopkins Hospital Date signed 10/14/47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G55970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G55970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 Braddish Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Braddish Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA LOUISE WENZING

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Herman G. A. Wenzing
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1862

8. AGE: Years	Months	Days	If less than one day
85	1	29	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Kraatz
13. Birthplace Germany

MOTHER
14. Maiden Name Sophie Falcke
15. Birthplace Germany

16 (a) Informant Mrs. Albert Kirwan
(b) Address 1505 Braddish Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received OCT 18 1947 (Local Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1947, at 6:40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 2 1947 to Oct 9 1947 and that I last saw her alive on Oct 9 1947

Immediate cause of death Cerebral Hemorrhage Caused by

Due to General Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none

Duration
5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Graham Jr. M. D.
Address 2219 Eyther Ave Date signed 10/11/47

X

G55971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G55971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3730 Hickory Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3730 Hickory Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Edward Hunt

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-24-2505

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Elizabeth Hunt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 1863

8. AGE: Years 84 | Months 7 | Days 27 | If less than one day hrs. min.

9. Birthplace Manchester, Carroll Co. Md. (Town, county, and state)

10. Usual Occupation Cotton Mill

11. Industry or business Retired 3 years

FATHER 12. Name Charles Frederick Hunt

13. Birthplace Germany

MOTHER 14. Maiden Name Lothia Keane

15. Birthplace Germany

16 (a) Informant Mrs. Mary E. Hunt

(b) Address 3730 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17 1947 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3[illegible] Falls Road

19 (a) OCT 13 1947 (Date rec'd by registrar) Wilmington for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1947 at 3:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 11 1947 and that I last saw h. [illegible] alive on Oct 11 1947

Immediate cause of death: Cardiac decomp: arteriosclerosis (CVD) — Duration 7

Due to: Bronchial asthma, — Duration

Due to: — Duration

Other Conditions Bronchopneumonia — Duration 6 da.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laverne J. Simonds M. D.

Address 5 [illegible] Dallyn Rd Date signed 10-13-47

V S 150

X

G55972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4824 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Murdock Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME EDNA MARY BUDDEMEIER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry W. Buddemeier

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) April 8, 1888

8. AGE: Years 59 | Months 6 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Howard Stevens
13. Birthplace Penna.

MOTHER
14. Maiden Name Sarah Arnett
15. Birthplace Maryland

16 (a) Informant Henry W. Buddemeier
(b) Address 525 Murdock Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-47 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD CEMETERY
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 13 1947 (Date received by Registrar) Custington for Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 9 1947. And that I last saw h— alive Oct 9 1947

Immediate cause of death: Cardiac Arrhythmia. — Duration

Due to: Senility Ovarian Cancer — Duration

Due to: Bowel obstruction — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 1212 St Paul St Date signed 10/10/47 M.D.

G55973 BCH #43549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Pittman Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Delores Jackson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1906

8. AGE: Years: 1 and 7 | Months | Days | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Jackson
13. Birthplace Va.

MOTHER 14. Maiden Name Mary Shute
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 14/47 (month) (day) (year)

(c) Cemetery or crematory
Location Greenbay Va

18 (a) Funeral director Mrs Pott A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

OCT 18 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 - 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11- 1947 to 10-12- 1947 and that I last saw her alive on 10-12- 1947

Immediate cause of death	Duration
Cardiac Failure	1 Week
Due to Marked Nutritional Anemia	4 Months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leslie Dunbar M. D.
Address Johns Hopkins Hosp Date signed 10-12-47

G55974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G55974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20. Days.
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town RURAL Severn (If outside city or town limits, write RURAL and give town)
(d) Street No. Donald Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George E Marlow, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-5484

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Effie Marlow
Nee-Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May. 27, 1889

8. AGE: Years	Months	Days	If less than one day
58	6	14	hr. min.

9. Birthplace NEWTON, N. C. (Town, county, and state)
10. Usual Occupation Structural Steel Worker
11. Industry or business Stone & Webster Corporation

FATHER
12. Name William Henderson Marlow
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name Nancy C. Hartzell
15. Birthplace UNKNOWN

16 (a) Informant Wife Effie B. Marlow
(b) Address Same Severn, Md, RFD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie Md.

OCT 13 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11-1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11-1947, to 10-11-1947, and that I last saw him alive on 10-11-1947

Immediate cause of death	Duration
Myocardial failure	2 hrs
Due to Coronary Occlusion	5 hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. D. Carlson (Jr.) M. D.
Address Balto Gen. Hosp. Date signed 10-11-47
for Dr. H. D. Davis, by Harry J. Moeller, M.D.

VS 150

C55975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. C55975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 S. Bethel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Tinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Queen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-28-15

8. AGE: Years 32 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name Walter Tinson
13. Birthplace Pa

MOTHER
14. Maiden Name Pearl Williams
15. Birthplace Pa.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13, 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 701 Baltimore ave

19 Oct 13 1947 (Date rec'd by registrar) (b) Interring for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1947, at 11 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1947 to Oct 9 1947 and that I last saw him alive on Oct 9 1947

Immediate cause of death	Duration
Intracranial hemorrage, bilat (internal capsule)	2 wks
Due to Malignant Hypertension	? 1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp Date signed 9 Oct '47

VS 150

C55976 - 114396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V95a

Registered No. C55976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2039 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha H. Rochell

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1912

8. AGE: Years	Months	Days	If less than one day
35	4	18	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Abe Dubose
13. Birthplace S.C.

MOTHER
14. Maiden Name Frances Madison
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14 19 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md.

18 (a) Funeral director Robert E McClain
(b) Address 15 15 McCulloh Street

OCT 10 1947 Huntington Milligan, M.D.
(Delayed only) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 19 47, at 2.45 pm

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 19 47 to Oct. 10 19 47 and that I last saw h[illegible] alive on Oct. 10 19 47.

Immediate cause of death	Duration
Cardiac failure.	
Due to Pneumonia lobular, terminal	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature William H. Vickery M.D.
Address Balto City Hosp. Date signed 10-11-47

VS 150

055977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1147

Registered No. 055977

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 N. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 N. Lexington St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frankie Mae Williams

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1934

8. AGE: Years 13 | Months 4 | Days 11 | If less than one day: hr. min.

9. Birthplace Wilmington, N. C. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Frank Miles
13. Birthplace N. C.

MOTHER 14. Maiden Name Arclancia Williams
15. Birthplace N. C.

16 (a) Informant Arclancia Washington
(b) Address 1511 N. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co., Md.

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsa. Ave.,

19 OCT 13 1947 (Date rec'd by registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10, 1947, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1947 to 10/10 1947, and that I last saw h[illegible] alive on 10/10 1947

Immediate cause of death — Abscess of Lung — Duration 6 weeks
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10/13/47

G55978

AB- 106646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 13B

Registered No. G55978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 11yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Tenpin Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helene Short

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29- 1935

8. AGE: Years	Months	Days	If less than one day
12	4	13	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernest Short
13. Birthplace S.C.

MOTHER
14. Maiden Name Martha Wall
15. Birthplace S.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Edmondson Ave.

19 (a) OCT 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1947, at 10.20 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 12-5 1946 to 10-11- 1947, and that I last saw h- or alive on 10-11- 1947

Immediate cause of death	Duration
Tuberculous Meningitis	10 mos.
Due to	
Due to	
Other Conditions Pott's Disease, Pulmonary TB (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arnold H. Becker M.D.
Address Balti City Hosp Date signed 10/14/47

G55979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V61

G55979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 Hiss Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose A Slechta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Joseph S Slechta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — March 5, 1893

8. AGE: Years 54 Months 7 Days 5 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wenceslaus Chvala
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Anna Scrna
15. Birthplace Czechoslovakia

16 (a) Informant Joseph M Slechta
(b) Address 2922 Hiss Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) OCT 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1947 at 1 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29 1947 to 10/10 1947 and that I last saw her alive on 10/10 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M. D.
Address St Joseph's Hosp Date signed 10-10-47

VS 150

931

G 55980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 181

Registered No. 55980

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 HRS
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 N. PATTERSON PARK (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CONROY, LOUISA MAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/5/41

8. AGE: Years	Months	Days	If less than one day
6	7	8	hr. min.

9. Birthplace BALTIMORE MD (Town, county and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER
12. Name VERNON Conroy
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name ELLIE [illegible]
15. Birthplace Balto., Md.

16 (a) Informant Vernon Conroy
(b) Address 1511 N Patterson Pk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Rd.

18 (a) Funeral director John C. Miller, Inc
(b) Address 2435 E Oliver St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1947 at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1947 to 10/11 1947 and that I last saw h[illegible] alive on 10/11 1947

Immediate cause of death (a) RESPIRATORY FAILURE — Duration

Due to (b) SHOCK

Due to (c) SEVERE BURN, 80%

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 10/11/47 at 3:00 PM
(c) Where did injury occur? BALTO (City or town) MD (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? NO
(e) Means of injury BURN - Playing with matches -- clothes caught fire

23. Signature Harry R. Ortel M.D.
Address 11 Dos. Hosp Date signed 10/11/47

For H. R. Ortel, M.D. by Howard S. Weeks, M.D.

C55981

BALTIMORE CITY HEALTH DEPARTMENT C55981 Registered No.

CERTIFICATE OF DEATH 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Harwood a
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Harwood a (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME Katherine J. Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph A.
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1862

8. AGE: Years 85 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name James McGovern
13. Birthplace (Ireland.

MOTHER
14. Maiden Name Dixon
15. Birthplace England

16 (a) Informant Joseph H. Smith
(b) Address 611 Harwood av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John A. McCown
(b) Address 1501 Greenmount a

19 (a) OCT 13 1947 (Date rec'd by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1947, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1947, to Oct 11 1947 and that I last saw h alive on Oct 10 1947.

	Duration
Immediate cause of death Chronic Myocarditis	1940
Due to	
Due to	
Other Conditions Acute Coronary Occlusion	1947

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No (Specify type of place) While at work?
(e) Means of injury

23. Signature D. W. Bishop M. D.
Address 503 Glenham a Date signed 10/13/47

G55982 G55982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 Light St
(c) Hospital or institution: South Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2715 Westfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Flint

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-6218

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11 1883

8. AGE: Years: 64 | Months: 7 | Days: 1 | If less than one day: hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation American Sugar Refinery

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Florence Flint
(b) Address 2915 Westfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Ave.

19 (a) OCT 13 1947 (Date rec'd by Registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1947 at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Oct 12 1947. and that I last saw him alive on Oct 12 1947.

Immediate cause of death: Acute myelogenous leukemia — Duration: 2 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Kelton, M.D.
Address South Balto Gen Hosp Date signed Oct 12

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G55983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45F G55983 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Jenkin Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County Luzerne
(c) City or town Duryea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 129 McAlpine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Rummerfield

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William Rummerfield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1857

8. AGE: Years	Months	Days	If less than one day
90	7	26	hr. min.

9. Birthplace Duryea, Pennsylvania
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Benjamin Davis
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Harry Rummerfield
(b) Address 1708 Eutaw Place

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 10/14/47 (month) (day) (year)
(c) Cemetery or crematory Marcea
Location Duryea, Pennsylvania

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 13 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13th 1947, at 5:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15- 1947, to Oct. 12th 1947, and that I last saw h alive on 19

Immediate cause of death	Duration
Carcinomatosis - generalized	
Due to Probable primary throat	
Due to Adv. atherosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Gracia, M. D.
Address 1700 Eutaw Place Date signed Oct. 13-47

55984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G55984

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town aberdeen (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mildred Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband ~~or wife~~ Raymond B. Clark

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 3/[illegible]/93

8. AGE: Years 54 | Months 7 | Days | If less than one day ..... hr. ..... min.

9. Birthplace Florence Howard Co. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mount Jay Shipley
13. Birthplace Frederick, Md

MOTHER
14. Maiden Name Lydia Musgrove
15. Birthplace Howard Co. Md

16 (a) Informant Bertha E. Shipley; Sister
(b) Address Aberdeen Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16-1947 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Park
Location Baltimore Md

18 (a) Funeral director Handy Funeral Home
(b) Address Aberdeen Md

OCT 14 1947 (Date rec'd by Registrar) (b) Huntington Mills

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1947 at 12:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1947 to 10/13 1947 and that I last saw her alive on 10/13 1947

Immediate cause of death	Duration
Recurrent Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben Gold, M.D.
Address University Hospital Date signed 10/13/47

G55985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G55985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1150 CLEVELAND ST.
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE. (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 1150 CLEVELAND ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY ANN BUTLER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife EDWARD J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 10, 1886

8. AGE: Years	Months	Days	If less than one day
61	4	1	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name PATRICK MORRISON
13. Birthplace [redacted] IRELAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant VIRGIE E. BUTLER
(b) Address 1150 CLEVELAND ST.

17 (a) BURIAL (Burial, cremation, removal) (b) Date thereof OCT. 14, 1947 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location FREDERICK AVE.

18 (a) Funeral director Joseph T. Cashman Jr.
(b) Address 419 N. Franklintown Rd.

OCT 14 1947 (Date rec'd by registrar) (b) [redacted]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1947, at 10 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10 1947 to 10-11 1947 and that I last saw h[redacted] alive on 10/11 1947

Immediate cause of death	Duration
Acute Cardiac Collapse	1 da
Due to Carcinoma of left Lung	2yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph T. Cashman M.D.
Address 6 Gladden Blvd Date signed 10/13/47

X

T655988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. T655988

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address — Jenkins Memorial 24
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 631 Harvey St (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kelly John A. KELLY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ellen W. Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 1852

8. AGE: Years 95 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Ireland (Town, county) and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Anthony Kelly
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Moran
15. Birthplace Ireland

16 (a) Informant Lawrence F Noonan
(b) Address 415 E. Clement St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14-1947 (month) (day) (year)
(c) Cemetery or crematory Loy Cathedral
Location Balto Md

18 (a) Funeral director C & B M Walter
(b) Address Pratt & Eutaw Sts

Oct 14 1947 (Date rec'd by registrar) Thornton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1947 1:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/47 19 to 10/11 1947
and that I last saw h alive on 10/9 19 47

Immediate cause of death Cardiac failure — Duration
Hypostatic C D D
Due to Emesis pulmonum
Due to Fracture L. femur
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 25/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10/9/47 at 10 a. M
(c) Where did injury occur? Jenkins Memorial Bldg 24
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No
(Specify type of place)
(e) Means of injury Fell down stairs
23. Signature C B M Walter M. D.
Address Stayton Md Date signed? 10/12/47

Howard J. Madden M. D. X

VS 150

55987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (937)

55987 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County.....
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 N. Charles St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Theodore B. Berkeley

3 (b) If veteran, name war ? | 3 (c) Social Security Account No. -

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife.....

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 57 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Photographer

11. Industry or business Unknown

FATHER
12. Name -
13. Birthplace -

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant Jay R. Nake-attorney
(b) Address 176 Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14 1947 (month) (day) (year)
(c) Cemetery or crematory new Cathedral
Location Balto Md

18 (a) Funeral director Poff & B. M. Walters
(b) Address Poth & Stricker Sts

OCT 14 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/47 19..... at 9:05 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature John R Dann M.D.
Medical Examiner.
Date signed 10/9/47

X

G55988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G55988

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING. Physicians: please write the causes of death clearly and legibly. Use no abbreviations or ditto marks. Be sure that the age, occupation and residence of each person is correctly stated, and that the cause of death is described with sufficient certainty for a scientific interpretation thereof. Do not record symptoms alone, but the diseases, injuries, and/or complications which caused death. Write plainly and use permanent black ink.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 Proctor st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Proctor st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward James Joseph

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
Male	White	Married

6 (b) Name of ~~husband~~ or wife Margaret Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30th 1915

8. AGE: Years	Months	Days	If less than one day
32	0	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business City of Balto.

FATHER
12. Name James Bell Joseph
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth O'Connor
15. Birthplace Unknown

16 (a) Informant Margaret Joseph
(b) Address 1107 Proctor St.

17 (a) Burial (b) Date thereof 10/15/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Josephs
Location Texas, Md.

18 (a) Funeral director William Cook Jnr.
(b) Address 1217 St. Paul St.

19 OCT 14 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11th 1947, at 12 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28 1947, to 10/11 1947, and that I last saw h[illegible] alive on 10/11 1947.

Immediate cause of death	Duration
Lung Abscess	2 weeks
Due to Peritonsillar Abscess.	4 weeks
Due to Retronsillar	
Other Conditions Broncho Pneumonia	2 weeks

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Bloom M. D.
Address 1206 E. Preston St. Date signed

115c

G55989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55989

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 Penrose Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Penrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Annie Zimmerer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: John Henry Zimmerer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17th 1882

8. AGE: Years 65 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name George Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Breitenbach
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth H. Selig
(b) Address 1937 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Jr.
(b) Address 1217 St. Paul St.

19 (a) OCT 14 1947 (Date rec'd by registrar) (b) Huntington Williams Mill

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to Oct 12th 1947 and that I last saw her alive on Oct 11 1947.

	Duration
Immediate cause of death: Coronary Heart Failure	48h.
Due to: Cardio-Renal Disease	
Due to: Arteriosclerosis	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Jr.
Address 1933 E. Baltimore St. Date signed 10/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G55990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G55990

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 Wilgrey Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 & 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Wilgrey Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha M. Holden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband ~~Richard~~ Thomas Holden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, ~~yr~~): Sept 1st 1883

8. AGE: Years: 64 | Months: 1 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Own

FATHER
12. Name: August F. Khroedel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary L Cono
15. Birthplace: Germany

16 (a) Informant: Mrs. E. Eidman
(b) Address: 1111 W. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/15/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 OCT 14 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 12 1947, at 11 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1947 to Oct 12 1947 and that I last saw h~~e~~r alive on Oct 12 1947.

Immediate cause of death: Cardio-Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Morris W. Steinberg M.D.
Address: 410 N. Milton Ave Date signed Oct 13

X

G55991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G55991

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4 - 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 740 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ODELL ROBERTS

3 (b) If veteran, name war: W.W # 2
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Edna V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-1907

8. AGE: Years 40 | Months 4 | Days 3 | If less than one day: hr. min.

9. Birthplace Winston-Salem, N. C. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Rosa Roberts
13. Birthplace N. C.

MOTHER
14. Maiden Name Edna Jefferies
15. Birthplace Va.

16 (a) Informant Edna V. Roberts
(b) Address 740 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-47 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Baltimore Maryland.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

19 OCT 14 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1947, at 7.45 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Dilatation of heart.
Edema of lungs.
Myocardial degeneration
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10-13-47

G55992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

146B

G55992 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1211 Light St.
(b) Street address ~~325 Montrose Ave~~
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County NONE
(c) City or town Baltimore Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 Montrose Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Imogene Mell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Harry Mell Jr.
6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) Oct. 30 1927

8. AGE: Years	Months	Days	If less than one day
19	11	19 12	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Bevens
13. Birthplace Pa.

MOTHER
14. Maiden Name Pauline Hill
15. Birthplace Pa.

16 (a) Informant Henry Mell Jr.
(b) Address 325 Montrose Ave. Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14-47 (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location Chase, Md.

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. Essex

19 OCT 14 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1947, at 2:41 PM

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 1947, to 10/11 1947, and that I last saw her alive on 10/11 1947

Immediate cause of death	Duration
CARDIAC FAILURE (3)	SUDDEN
Due to PRE-ECLAMPSIA	3 DAYS
Due to PREMATURE SEPARATION (1/3) OF NORMALLY IMPLANTED PLACENTA	6 HOURS
Other Conditions PREGNANCY 24 WEEKS LOW CERVICAL CESAREAN SECTION (Include pregnancy within 3 months of death)	

Date of operation 10/10/47 8:45 P.M.
Major findings of operation: SAME AS ABOVE
of autopsy: NONE GROSSLY

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D M Dixon
Address 819 Md Avenue Baltimore Date signed 10/11/47

VS 150

55993

438409

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 122a

Registered No. G55993

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S. C. (b) County
(c) City or town Columbia (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Saluda Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie Lifchez

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Mose Lifchez

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 4/28/96

8. AGE: Years	Months	Days	If less than one day
51	5	16	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation house-wife

11. Industry or business

FATHER
12. Name Mandel Stein
13. Birthplace Russia

MOTHER
14. Maiden Name Hanna Caplan
15. Birthplace Russia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-47 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place

19 (a) 10-14-1947 (Date received by Registrar) (Huntington Williams, M.D. Registrar)

DC

VS 190^A F 10 16

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1947, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1947 to 10/14 1947 and that I last saw her alive on 10/14 1947

Immediate cause of death: Cardio-respiratory failure — Duration 3 hrs

Due to: Atelectasis — 4 days

Due to: Diaphragmatic hernia, hiatus type — 51 yrs

Other Conditions: Tension pneumothorax

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Elgerton

Address Johns Hopkins Hosp Date signed 10/14

X

C55994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

C55994 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2317 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Harlem Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Barline

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George N. Barline

6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr.): Apr 5 1863

8. AGE: Years: 84 | Months: 6 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER
12. Name: Jacob Knodt
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Ellick
15. Birthplace: Germany

16 (a) Informant: Mrs. Pauline Boyce
(b) Address: 2317 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 15-1947 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: City

18 (a) Funeral director: Mr. & Mrs. John H. Teufel & Son
(b) Address: 5311 Edmondson Ave.

19 OCT 14 1947 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 12 1947, at 3-55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1947 to Oct 12 1947 and that I last saw her alive on Oct 12 1947.

Immediate cause of death: Chronic Cardio vas dis. — Duration: 7

Due to:

Due to:

Other Conditions: Cirrhosis of Liver

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Ernest W. Rahn M. D.

Address: 1720 Pop Gr St Date signed: 10/13/47

VS 150

937

655995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

655995 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 453 Brunswick St
(c) Hospital or institution: 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 453 Brunswick St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace O. Steinacker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Leonard A. –

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1880

8. AGE: Years	Months	Days	If less than one day
67	1	19	hr. min.

9. Birthplace Ludlow Ind.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name John Railsback
13. Birthplace Ind.

MOTHER
14. Maiden Name Mary Potter
15. Birthplace Ind.

16 (a) Informant Leonard C. Steinacker Son
(b) Address 453 Brunswick St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 14 Oct 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. Albert Wenk
(b) Address 420 Eutaw Place

OCT 14 1947 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1947 at 6:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Fulcomer M.D.
Medical Examiner.
Date signed 10/10/47

C55996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C55996

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 56 GORMAN AVE.
(c) Hospital or institution: ********** 20 ***
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 56 GORMAN AVE. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No) If yes, name country

3 (a) FULL NAME HENRY J. ZINCK

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-7503

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife CLARA L. ZINCK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 / 9 / 1885

8. AGE: Years 62 | Months 3 | Days 1 | If less than one day hrs. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Watchman & Clerk for
11. Industry or business Southern States Corp.

FATHER
12. Name Henry Zinck
13. Birthplace Maryland

MOTHER
14. Maiden Name Lena Broening
15. Birthplace Maryland

16 (a) Informant Mrs. Clara L. Zinck (wife
(b) Address 56 Gorman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14/47 (month) (day) (year)
(c) Cemetery or crematory St. Pauls Cemetery
Location Violetsville, Maryland

18 (a) Funeral director F.B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE

19 OCT 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 10 the 47 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Oct 10 1947, and that I last saw h. alive on 10/10 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension	3 yrs
Due to Arterio Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. A. Asher M. D.
Address Baltimore & Smallwood Sts.

Baltimore & Smallwood Sts. X

(G5599?7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

(G5599?7 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 Homewood Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) About 73 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Homewood Terrace (If rural give location)
(e) Citizen of foreign country? ------ (Yes or No) If yes, name country -------

3 (a) FULL NAME Katie M. Bennett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas J. Bennett
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
About 73	---	--	-- hr. --- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: -------

FATHER
12. Name: William J. Cranblitt
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Adelaide Switzer
15. Birthplace: Maryland

16 (a) Informant: Arthur T. Bennett
(b) Address: 206 Homewood Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Means and Son
(b) Address: 805 N. Calvert Street

19 (a) OCT 14 1947 (date received by registrar) (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1947 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to Oct 13 1947 and that I last saw h[illegible] alive on Oct 13 1947

Immediate cause of death	Duration
[illegible]	yrs
Due to Cerebral Softening Senility	yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 20 E. Preston St. Date signed Oct 14 1947

X

C55998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 122a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. Montgomery Rd.
(If no street give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Louise Kern

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife. Godefried Kern

6 (c) If alive, give age years

Deceased

7. Birth date of deceased (mo., day, yr.) Aug 19 1870

8. AGE: Years 77 | Months 1 | Days 21 | If less than one day ____hr. ____min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name John Werner
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown, Elizabeth
15. Birthplace Germany

16 (a) Informant ~~Self~~ Werner Kern
(b) Address Montgomery Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Ave

18 (a) Funeral director Henry H Withe
(b) Address 4101 Edmondson Ave

19 (a) (Date received by Registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Oct 1947, at 5 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Sept 1947 to 13 Oct 1947 and that I last saw h er alive on 13 Oct 1947

	Duration
Immediate cause of death: Peritonitis, acute	11 days
Due to Perforation, small intestine	14 days
Due to Hernia, femoral, strangulated	16 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1 Oct 47

Major findings of operation: Strangulated femoral hernia; perforated sm. int.

of autopsy: 13 Oct Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard M. Garrett M. D.
Address Church Home & Hosp Date signed 13 Oct 47

X X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C55999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

Registered No. C55999

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laymans Dubeland.
(c) Hospital or institution: Mt. Pleasant Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. ---------- (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley B. Parks Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217 18 5986

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife Catherine E. Parks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1897.

8. AGE: Years	Months	Days	If less than one day
50	4	2	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Warehouse Work
11. Industry or business May Co.

FATHER
12. Name Samuel L. Parks
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Duffy
15. Birthplace Ireland

16 (a) Informant Mrs. Catherine E. Parks
(b) Address Sykesville, Md.

17 (a) Burial (b) Date thereof Oct. 15/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry A. Tuttle
(b) Address 4101 Edmondson Ave.

19 (a) OCT 14 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 October 1947, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1947 to 11 Oct. 1947, and that I last saw h[illegible] alive on 11 Oct 1947

Immediate cause of death	Duration
Cardiac Resp Failure	
Due to Renal Insufficiency	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Total

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leiter A. Hall Jr. M. D.
Address Mt. Pleasant Gen. Hosp. Date signed 11 Oct 47

G56000 BAILEY BALTIMORE CITY HEALTH DEPARTMENT G56000

CERTIFICATE OF DEATH 46 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 Riggs Ave.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE ELWOOD BAILEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~Husband~~ or wife Anna E. Lakeland Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1867

8. AGE: Years	Months	Days	If less than one day
80	0	23	hr. min.

9. Birthplace Springfield, Ohio (Town, county, and state)
10. Usual Occupation Pattern maker, Retired
11. Industry or business American Brakeshoe Co.

FATHER
12. Name Amos V. Bailey
13. Birthplace Harford Co.

MOTHER
14. Maiden Name Hanorah Barnes
15. Birthplace Harford Co. Md.

16 (a) Informant Mrs. Anna E. Bailey
(b) Address 1812 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/47 (month) (day) (year)
(c) Cemetery ~~XXXXXX~~ Woodlawn Cem.
Location Woodland, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) OCT 14 1947 (Date rec'd by reg.) (b) Registrar

V S 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Oct. 11, 1947, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Oct 11 1947.
and that I last saw h(im) alive on Oct. 11 1947

Immediate cause of death Carcinoma ? Stomach — Duration unknown

Due to

Due to

Other Conditions Arthritis — Yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Ashman M.D.
Address 1921 W. North Ave. Date signed 10/13/47 M.D.

Remarks for Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S56001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. S56004

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd.
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Mt. Royal Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER H. BOWEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Bertha Hambleton Bowen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1868

8. AGE: Years	Months	Days	If less than one day
79	9	5	hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)
10. Usual Occupation Retired Bookkeeper
11. Industry or business

FATHER
12. Name Joseph M. Bowen
13. Birthplace Pa.

MOTHER
14. Maiden Name Eliza Hanway
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. Dorothy Denton
(b) Address 1429 Mt. Royal Ave.

17 (a) Burial (b) Date thereof 10/14/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) [illegible] (b) Huntington Milliques M.D. (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 October 1947, at 10:35 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1947, to 12 Oct 1947, and that I last saw h[illegible] alive on 12 Oct 1947.

Immediate cause of death Pulmonary Edema — Duration 12 hrs

Due to Hypertensive C.V. Disease — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl L Royer M.D.
Address 142 Westview Place Date signed 13 Oct 47

G56002 BCH F 81297 G56002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Genl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town, write RURAL and give town)
(d) Street No. 118 N Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gary Lee Bradford

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1943

8. AGE: Years	Months	Days	If less than one day
4	2	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Kenneth E. Bradford
13. Birthplace Reading, Pa.

MOTHER
14. Maiden Name Edna C. Rothage
15. Birthplace Balto., Md.

16 (a) Informant Mr. Kenneth E. Bradford
(b) Address 118 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) OCT 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1947, at 6 30 P M

21. I certify that I took charge of the remains described above, held an Aug Ex Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock traumatic

Due to fracture of skull & both femurs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct 12th 1947 at about 9 a.m.
(b) Where did injury occur Hilton St near Pheasant Lane
(c) Did injury occur at home, on farm, industrial place, in public place? On public highway While at work? No
(d) Means of injury Child fell from moving automobile

23. Signature William E. Telford M.D. Medical Examiner.
Date signed Oct 12, 1947

VS 151

G56003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G56003

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2321 Callow Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2321 Callow Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE WOLF ROSENBERG.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Albert Rosenberg of
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1863

8. AGE: Years	Months	Days	If less than one day
84	3 4	24	hr. min.

9. Birthplace Caladonia, New York. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Wolf,
13. Birthplace Germany.

MOTHER
14. Maiden Name Sophie Meyers,
15. Birthplace New York City.

16 (a) Informant Mr. Albert Rosenberg of M.
(b) Address 2321 Callow Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/15/47. (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1902 Eutaw Place.

19 OCT 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct. 13th. 19 47, at 12.10

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30, 1947, to Oct 13 1947, and that I last saw h[illegible] alive on Oct 12 1947.

Immediate cause of death: Coronary Thrombosis — Cerebral Hemorrhage — Duration 24 hrs 5 minutes

Due to

Due to

Other Conditions: Arteriosclerosis — Diabetes Mellitus

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harry Lachman
Address 2322 Callow Ave. Date signed Oct 13 1947 D.

VS 150

X

G56004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

G56004 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Light & Barre Sts
(c) Hospital or institution McCormick & Co. 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1656 W. North Ave (If rural give location)
(e) Citizen of foreign country? Na (Yes or No)
If yes, name country

3 (a) FULL NAME June Bell

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No. 212-01-8863

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Hilda Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 893

8. AGE: Years	Months	Days	If less than one day
53	9	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business McCormick & Co Inc

FATHER
12. Name Sam Bell
13. Birthplace Maryland

MOTHER
14. Maiden Name Mathilda Bauer
15. Birthplace Maryland

16 (a) Informant Mrs. Hilda Wimberly Bell
(b) Address 1666 W. North Ave

17 (a) Burial (b) Date thereof 10-18-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md.

18 (a) Funeral director Dent & Sindlinger & Son
(b) Address 1902 Eutaw Pl

19 (a) OCT 14 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13-1947, at 4 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion
Secondary Arteriosclerosis
Hypertrophy & dilatation of Heart
Due to

Other Conditions Chronic Glomerulo-nephritis
Congestion of all viscera
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullis M.D. Medical Examiner.
Date signed 10/14/47

G56005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

Registered No. G56005

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1028 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 W Franklin St (If rural give location)
(e) Citizen of what country? Jackson (Yes or No) If not, name country

3 (a) FULL NAME Henrietta Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1891

8. AGE: Years 56 | Months 2 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER 12. Name Alexander Jones
13. Birthplace Md

MOTHER 14. Maiden Name Mary Jennings
15. Birthplace Md

16 (a) Informant Catherine Jackson
(b) Address 1028 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/47 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location Md

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Pennsylvania Ave

19 OCT 14 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13th 1947 at 11:30 M

21. I certify that I took charge of the remains described above, held an Inq Ed Coup thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Syphilitic Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Helbrecht M.D. Medical Examiner.
Date signed Oct 14 1947

X

G56006

LR 90538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No. G56006

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. none (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Hasse; HASSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18-1874

8. AGE: Years	Months	Days	If less than one day
73	1	25	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bernard (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Busch (D)
15. Birthplace Germany

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/47 (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) OCT 14 1947 (Date rec'd by registrar) (b) [signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13- 1947 at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11 - 6 - 1944 to 10-13- 1947; and that I last saw him alive on 10- 13 1947

Immediate cause of death Bronchogenic Ca c Extension to Adrenals — Duration

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Faber M. D.
Address Balto. City Hosp. Date signed 10-13-47

VS 150

G56007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

115c

G56007
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 S
(c) Hospital or institution Mercy Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Bellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary L. Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1941

8. AGE: Years	Months	Days	If less than one day
6	4	28	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lester L. Brooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Bernice Patterson
15. Birthplace Maryland

16 (a) Informant Albert E. Patterson
(b) Address 1424 Bellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12th 1947, at 6 12 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection of Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxia by Vomiting -

Due to Convulsions following an acute Naso-pharyngitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D. Medical Examiner.
Date signed Oct 13, 1947

G56008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G56008

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mdical - Surgical
(c) Hospital or institution: Maryland Gen. Hosp. 13
(d) Length of stay in hospital or inst. (~~yrs.~~, ~~mos.~~, or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Falls Rd. #11
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Daisy Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Wh

6 (a) ~~Single, married, widowed~~, or divorced. married

6 (b) Name of husband or wife Joseph Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 22 Aug 1888

8. AGE: Years 59 | Months 1 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Harris
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice ?
15. Birthplace Maryland

16 (a) Informant Howard R. Harris
(b) Address 3808 Falls Road.

17 (a) Burial (b) Date thereof Oct 15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Paul's
Location Balto Co. Md.

18 (a) Funeral director Clemons & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) Oct 14 1947 (b) Huntington Williams
(Date rec'd by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Oct. 1947, at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Oct. 1947 to 12 Oct. 1947, and that I last saw her alive on 12 Oct. 1947

Immediate cause of death: Generalized peritonitis — Duration: 7 Oct

Due to: Leakage following resection of sigmoid colon

Due to: Carcinoma sigmoid

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7 Oct. 1947

Major findings of operation: Carcinoma sigmoid

of autopsy: Generalized peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.T. McGoogan M. D.

Address Md. Gen. Hospital Date signed 12 Oct 1947

G56009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G56009

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3119 Kentucky Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEROY Z. CAIRNS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Matilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11 1902

8. AGE: Years 45 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business

FATHER
12. Name Harry Cairns
13. Birthplace Balt.

MOTHER
14. Maiden Name Lillian Clayton
15. Birthplace Balto.

16 (a) Informant Matilda Cairns
(b) Address 3119 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date there Oct. 15/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Wm. L. McLean
(b) Address 3000 E. Balto. St

19 OCT 14 1947 Huntington Williams, Mgr. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11/47 19 at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weis, M.D. Medical Examiner.
Date signed 10/17/47

VS 181

G 56010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

S-56010 V 186a

Registered No. G 56010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 CAROLINE ST
(c) Hospital or institution: ST JOSEPHS HOSP. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N MILTON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE LOCHNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife MARGARET
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/24/61

8. AGE: Years	Months	Days	If less than one day
86	5	18	hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name George J Lochner
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Margaret Lochner
(b) Address 206 N Milton Ave.

17 (a) Burial (b) Date thereof 10/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Red.
Location Belair Rd.

18 (a) Funeral director John A. Moran
(b) Address 3000 E Balto St.

19 (a) 10/11/47 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

NAME AND ADDRESS OF INFORMANT

Mrs. Geo. J. Lochner
206 N. Milton Ave.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12 1947, at 2 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1947, to 10/12 1947, and that I last saw h[illegible] alive on 10/12/1947

Immediate cause of death: PNEUMONIA BILATERAL — Duration

Due to CARDIORESP FAILURE

Due to C.V. DISEASE

Other Conditions FRACTURE RIGHT HIP. FEMUR
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operations: PNEUMONIA

of autopsy C.V.D. ARTER.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 10-1 1947 at ? M
(c) Where did injury occur? BALTO MD
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME While at work? NO
(Specify type of place)
(e) Means of injury Fall (trip to floor)

23. Signature John B Wells M.D.
Address St Joseph Hosp Date signed 10-12-47
M. D.

Howard J. Moreau, M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G56011

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 E. North Ave:
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419- E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Ferraro - Giacomo Gallo -

3 (b) If veteran, name war: 1st WORLD WAR
3 (c) Social Security Account No. 112-10-4362

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary Ferraro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25-1895

8. AGE: Years	Months	Days	If less than one day
51	9	19	hr. min.

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Mary Ferraro
(b) Address 419 E. North Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18-47 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Aliquippa Pa.
18 (a) Funeral director E. Plowath Armacost
(b) Address 3911 Liberty Heights
OCT 14 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1947, at 5 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1947, to Oct 14 1947, and that I last saw h. alive on Oct 13 1947.

Immediate cause of death	Duration
Carcinomatosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June - 1947
Major findings of operation: Carcinoma of lung
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jack J. Singer
Address 506 E North Ave Date signed 10/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G56012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 E. Monument
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roland Hyman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Gladys Hyman
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 6/8/04

8. AGE: Years	Months	Days	If less than one day
43	4	3	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Peter Hyman
13. Birthplace N.C

MOTHER
14. Maiden Name Sylvia Gaskins
15. Birthplace N. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Joseph D. Lochte
18 (a) Funeral director 1304 N. Central Ave
(b) Address Huntingtown Williamsport, Md.
19 (a) (b) Registrar
(Date received by Local Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1947, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1947, to 10/11 1947.
and that I last saw him alive on 10/11 1947
Immediate cause of death Uremia — Duration 1 mo
Due to arteriosclerotic cardio-vascular + renal disease — Duration Unknown
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp Date signed 12 Oct 47

G56013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: D.O.A.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 d
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 17 S. Regester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Samuel Lloyd

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1889

8. AGE: Years: 57 | Months: 9 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Balto. Md (Town, county and state)

10. Usual Occupation: Laborer

11. Industry or business:

FATHER
12. Name: Samuel Lloyd
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Mary D. Trott
15. Birthplace: Balto. Md

16 (a) Informant: Wm. E. Lloyd
(b) Address: 1313 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/15/47 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location: Joseph B. Lackey Jr

18 (a) Funeral director: 1304 N. Central Ave
(b) Address:

OCT 14 1947 (Date rec'd by registrar) (b) Huntingtown Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/12 1947, at 9 A M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: C. P. Colombe M.D. Medical Examiner.
Date signed: 10/13/47

C56014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. C56014

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Ellamont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis A. N. Hirshauer

3 (b) If veteran, name war	3 (c) Social Security Account No. 213-10-2511

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28 1876

8. AGE: Years	Months	Days	If less than one day
60 61	11 0	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Victor Hirshauer
13. Birthplace Bohemia

MOTHER
14. Maiden Name Malvina Simek
15. Birthplace Bohemia

16 (a) Informant Mary Hirshauer
(b) Address Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/37 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Belair Rd

18 (a) Funeral director Geo M. Fair Son
(b) Address 800 N. Wolfe St.

19 OCT 14 1937 (Date rec'd by Registrar) (c) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1937 at 1:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Pollitt M.D. Medical Examiner.
Date signed 10/16/37

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Reg. No. 056015

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address EUTAW PLACE & LANVALE ST.
(c) Hospital or institution:
HOTEL ALTAMONT.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17YRS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
City or town BALTIMORE CITY
(If outside city or town limits, write RURAL and give town)
(d) Street No. EUTAW PLACE & LANVALE ST
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY.ALICE WILE.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29-1856

8. AGE: Years 90 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Emmitsburg Md.
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER 12. Name David Wile
13. Birthplace Md

MOTHER 14. Maiden Name Mary Ann Gelbaas
15. Birthplace Md

16 (a) Informant Miss Mary J. Bushey
(b) Address Altamont Hotel

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Md

18 (a) Funeral director Bertram R. Fox
(b) Address 2334 N. Gilmor St.

19 (a) Oct 14 1947 (Date rec'd by local registrar) Registrar for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH OCTOBER 13 1947, at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 14 1947 to OCT 13 1947, and that I last saw her alive on OCT 13 1947.

Immediate cause of death		Duration
CHRONIC MYOCARDITIS	SEPT 14	1947
Due to		
ARTERIOR SCLEROSIS		1947
Due to		
Other Conditions		
CHRONIC MITRAL REGURGITATION		

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul F Williams M.D.
Address 3013 ST PAUL ST. Date signed OCTOBER 14 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G56016 LW 112952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56016

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 240 S. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nicholas Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24-1881

8. AGE: Years 66 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Pete Johnson
13. Birthplace Greece

MOTHER
14. Maiden Name Mae Zambeca
15. Birthplace Greece

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-47 (month) (day) (year)
(c) Cemetery or crematory Cemetery Greek
Location Windsor Mill Rd.

18 (a) Funeral director Lambros Bros.
(b) Address 440 E. North ave

19 OCT 14 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9- 1947 at 12:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1947 to 10-9 1947, and that I last saw him alive on Oct. 9- 1947.

Immediate cause of death: Pulmonary Edema — Duration 4 hrs.

Due to Myocardial failure

Due to Hypertensive C.V.D. — 3 yrs

Other Conditions Myocardial Infarction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Beahan

Address Baltimore City Hos. Date signed Oct. 47

VS 150

G56017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G56017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2320 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Brunning

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clementine Brunning

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1867

8. AGE: Years	Months	Days	If less than one day
80	-	12	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Marine Engineer

11. Industry or business

FATHER
12. Name Johan P Brunning
13. Birthplace P Germany

MOTHER
14. Maiden Name P Dont Kenow
15. Birthplace P Germany

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2000 E Oliver St

19 (a) OCT 14 1947 (Date rec'd by registrar) (b) Huntingtown, Williamsburg, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1947 at 1 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 10/7/11 1947

Immediate cause of death Cerebral Hemorrhage — Duration 2 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Dipalma M. D.
Address Johns Hopkins Hospital Date signed 10/14/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F56018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered No. F56018

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 547 E. Fort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 547 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME William H. House

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Lona Coverstone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/15/1858

8. AGE: Years	Months	Days	If less than one day
89	7	29	hr. min.

9. Birthplace Brunswick, Md.
(Town, county, and state)
10. Usual Occupation Retired Employee Of
11. Industry or business Norfolk & Western R.R.

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Family
(b) Address 547 E. Fort Ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/16/47 (month) (day) (year)
(c) Cemetery or crematory
Location Shenandoah Va.

18 (a) Funeral director James L. McCauley
(b) Address 1450 E. Fort Ave.

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1947 at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9 1947 to Oct 14 1947 and that I last saw h[illegible] alive on Oct 9 1947

Immediate cause of death	Duration
Terminal Pneumonia	?
Chronic nephritis	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. Ellison M.D.
M. D.
Address 107 E. West St. Date signed 10/14/47

VS 150

X

G56019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

G56019 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fawn and Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 W. Mulberry St. (Number if any, or location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Munford

3 (b) If veteran, name war W.W. #1

3 (c) Social Security Account No.

4. Sex Mal

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25 1891

8. AGE: Years 56 | Months 4 | Days 8 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Elizabeth Munford
(b) Address 1008 W. Mulberry St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/15/47 (month) (day) (year)

(c) Cemetery or crematory Balto. National Cem.
Location

18 (a) Funeral director Chas. G. Cooper
(b) Address 512 N. Carrollton

19 Oct 14 1947 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1947, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1947 to 10/3 1947 and that I last saw h.i.m.a. alive on 10/3 1947.

Immediate cause of death	Duration
Central Respiratory Failure	
Due to Multiple thrombi; bilateral pulmonic	2 days
Due to Coronary occlusion; shock	Unknown
Other Conditions Fracture - bronchopneumonia;	2 days

(Include pregnancy within 3 months of death)

Date of operation 10/2/47

Major findings of operation: Fracture confirmed

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David J. Shilz M.D.
Address Univ. Hosp. Date signed 10/5/47

VS 150

G56020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56020 Registered No. 51B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Mt. Airy (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marshall O. Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of ~~husband or~~ wife Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1860

8. AGE: Years	Months	Days	If less than one day
87	2	9	hr. min.

9. Birthplace Frederick Co. Maryland (Town, county, and state)

10. Usual Occupation FARMER Retired

11. Industry or business

FATHER 12. Name Thomas W. Boone
13. Birthplace Maryland

MOTHER 14. Maiden Name Nancy Williams
15. Birthplace Maryland

16 (a) Informant Miss Blanche Boone
(b) Address Military Rd. Frederick, Md.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10-16-47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Linganore
Location Unionville, Maryland

18 (a) Funeral director C. M. Waltz
(b) Address Winfield, Md.

19 OCT 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1947, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 13 1947 and that I last saw him alive on Oct 13 1947

Immediate cause of death Respiratory & cardiac failure following prostatic tumor — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H Lower M. D.
Address University Hosp Date signed 10-13-47

G56021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Cause of death clearly and legibly. Physicians: please write the exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 Eutaw Pl
(c) Hospital or institution: Dod Wm Cook Funeral Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 St Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gerald F. Loux

3 (b) If veteran, name war

3 (c) Social Security Account No. 188-05-5247

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Anna Loux

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17th 1903

8. AGE: Years	Months	Days	If less than one day
44	5	26	hr. min.

9. Birthplace Morrisstown Pa
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business Beautician Restaurant

FATHER
12. Name William O. Loux
13. Birthplace Tylersport Pa.

MOTHER
14. Maiden Name Virginia Grady
15. Birthplace Pa.

16 (a) Informant Anna Loux
(b) Address 2506 St. Paul St.

17 (a) Burial (b) Date thereof 10/15/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 15 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1947 at 8:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardiditis

Due to Coronary Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 10/13/47

G56022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56022

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4717 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4717 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T. Treadon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Treadon

6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr. Oct 21, 1855

8. AGE: Years	Months	Days	If less than one day
92	11	21	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Charles Carroll
13. Birthplace Md.

MOTHER
14. Maiden Name Eugenia Carroll
15. Birthplace Md.

16 (a) Informant Lillian Avery
(b) Address 4717 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15th (month) (day)
(c) Cemetery or crematory Arbutus M Park
Location Arbutus Md.

18 (a) Funeral director Mrs Robt. C Elliott
(b) Address 1129 N. Carlton St.

OCT 15 1947
(Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11-47 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-1947 to 10-11-1947 and that I last saw h[illegible] alive on 10-11-1947.

Immediate cause of death: Myocarditis and Arterio-Sclerosis — Duration: 3 days, 2 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jas R. Blake D.
Address 1327 N. Central Ave.

Balto 2, Md. × 10/14/47

G56023 BC# B 81809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G56023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 677 Pierce Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NATHANEL BURKETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1947

8. AGE: Years	Months	Days	If less than one day
	4	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Nathaniel Burkett
13. Birthplace S. C.

MOTHER
14. Maiden Name Margaret Knight
15. Birthplace N. C.

16 (a) Informant Nathaniel Burkett, Sr.
(b) Address 677 Pierce Street

17 (a) Burial (b) Date thereof 10-15-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Date received by local registrar OCT 15 1947 (b) Registrar Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1947, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐, and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital heart disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 10-13-47

G56024 BHF G-68960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. G56024

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Broadway (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country — — —

3 (a) FULL NAME Gerald T. Krus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1 — 29 — 1947

8. AGE: Years 0 | Months 8 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER: 12. Name Thaddius J. Krus
13. Birthplace Md.

MOTHER: 14. Maiden Name Helen L. Dimbowski
15. Birthplace Md.

16 (a) Informant Thaddius J. Krus
(b) Address 125 S. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-47 (month) (day) (year)
(c) Cemetery or crematory St. Michael's
Location Germau Hill Road.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) 10 15 1947 (Date received by registrar) (b) Burington for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1947, at 9:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1947 to 10/13 1947 and that I last saw h/s alive on 10/13 1947

Immediate cause of death	Duration
Shock	
Due to Operation	
Due to	
Other Conditions Hydrocephalus	

(Include pregnancy within 3 months of death)

Date of operation 10/13

Major findings of operation: Hydrocephalus

of autopsy: Bleeding from Dural Sinus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ed. Shelkin M. D.

Address Date signed 10/13

X

G56025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V46E

G56025 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Block E. Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 Brookfield ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Gamerman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/15/1883

8. AGE: Years	Months	Days	If less than one day
63	9	29	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Jewelery Store

FATHER
12. Name Henry Gamerman
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Letowitz
15. Birthplace Russia

16 (a) Informant Mrs Rebecca Gamerman
(b) Address 2404 Brookfield ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15/47 (month) (day) (year)
(c) Cemetery or crematory Bnai Jacob Lodge
Location Bowley Lane & Philadelphia Rd

18 (a) Funeral director Abel Levinson & Bros
(b) Address 124-26 W. North ave

OCT 15 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/47 19 , at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1947 to 10/14 1947 and that I last saw HIM alive on 10/14 1947.

Immediate cause of death Lymphosarcoma of Intestine — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley Miller M. D.
Address Date signed

G56026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 55c

Registered No. G56026

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3055 Brighton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3055 Brighton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Domenica M. Maraglia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10 - 1875

8. AGE: Years 71 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Giovanni Maria Serio
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Serio
15. Birthplace Italy

16 (a) Informant Sarah Serio
(b) Address 3041 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Rd.

18 (a) Funeral director Joseph Savage & Son
(b) Address 201 S. Greenmount Ave

OCT 15 1947 (Date rec'd by registrar) (By) Huntington Williams III

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1947, at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2, 1947 to Oct 12, 1947 and that I last saw her alive on Oct. 12, 1947.

	Duration
Immediate cause of death Carcinoma of Thyroid gland.	6 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ira Zimmerman M.D.
Address Medical Arts Bldg Date signed 10/15/47

G56027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56027

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Mohawk Ave.
(c) Hospital or institution:
Anderson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4330 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie S. Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-5-66

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John B. Stewart
13. Birthplace

MOTHER
14. Maiden Name Rebecca A.
15. Birthplace

16 (a) Informant Mrs. John B. H. Dunn
(b) Address 4330 Roland Ave.

17 (a) Burial (b) Date thereof 10/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location North Ave. & Greenmount

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

OCT 15 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1947 to 10-14 1947, and that I last saw her alive on 10-14 1947

Immediate cause of death: Acute Congestive Heart failure — Duration: 2 dys
Due to: Arterio Sclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard F. Warren M. D.
Address 2604 Garrison Ave. Date signed

VS 150

G56028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56028

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 W. Franklin St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. GRAY

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Mary Julia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/21/1871

8. AGE: Years 76 | Months 4 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Wm. Gray
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Nancy Jones
15. Birthplace Richmond, Va.

16 (a) Informant Clarance Jones (Son)
(b) Address 1123 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave.

19 (a) 10-15 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/47 19..... at 10:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1947 to Oct 12 1947 and that I last saw h... alive on Oct 10 1947.

Immediate cause of death: Cardiac Vascular Obstruction — Duration: 1yr
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Watt M.D.
Address 5154 Belvedere Ave. Date signed 10/15/47

X

G56029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 61

G56029 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 345 Folcroff Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT J PIZLO

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-6042

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Genevie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-2-1900

8. AGE: Years	Months	Days	If less than one day
47	6	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business National Cash
FATHER 12. Name John Pizlo
13. Birthplace Poland
MOTHER 14. Maiden Name Sophia
15. Birthplace Poland
16 (a) Informant Genevie Pizlo
(b) Address 345 Folcroft St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co.
18 (a) Funeral director Wm. D. Fialkowski
(b) Address 2007 Eastern Ave
19 OCT 15 1947 (Date rec'd by registrar) (Huntington Williams Hall)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1947, at 10.55 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchopneumonia,
myocardial degeneration,
Diabetes mellitus (history)
DUE TO abscess of spinal cord

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10-13-47

VS 151

C56030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C56030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2718 Mura Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2718 Mura Sted
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John C. Bontren Vontrans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Bernardin

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) June 5. 1897

8. AGE: Years	Months	Days	If less than one day
50	4	7	....hr. ....min.

9. Birthplace Baltimore. Md
(Town, county, and state)

10. Usual Occupation Brain operator

11. Industry or business

FATHER
12. Name John Vontrans
13. Birthplace Balto Md

MOTHER
14. Maiden Name Victora Dell
15. Birthplace Balto Md.

16 (a) Informant Bernardin Vontrans
(b) Address 2718 Mura St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17 '47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Martin J. Conroy
(b) Address 1600 Hollins St.

19 OCT 15 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1947, at 6 A. M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Moldeis M.D.
Medical Examiner.
Date signed 10/14/47

G56031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G56031 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 S. Durham Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 S. Durham Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Regina Lewczak

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband Alexander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1894

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Krol
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna Drozd
15. Birthplace Poland

16 (a) Informant John Lewczak (Son)
(b) Address 723 South Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-47 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

OCT 15 1947 (Date rec'd by Registrar) (Signature of Registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14th 1947, at 9.27 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1947, to Oct. 14 1947, and that I last saw h- alive on Oct. 14, 1947.

Immediate cause of death	Duration
Cerebral Apoplexy	11 Days
Due to Cerebral Arteriosclerosis & Chr. Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address 7002 E Baltimore Date signed 10/14/47

G56032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56032 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County Dade
(c) City or town Miami (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 N.E. 57th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Paul Dunham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Eva Dunham
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 6/8/08

8. AGE: Years	Months	Days	If less than one day
39	4	6	hr. min.

9. Birthplace New York N.Y. (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business

FATHER 12. Name John T. Dunham
13. Birthplace N.Y.

MOTHER 14. Maiden Name Sally Flowers
15. Birthplace

16 (a) Informant Mrs. Eva Dunham
(b) Address 118 N.E. 57th Miami Fla.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18-47 (month) (day) (year)
(c) Cemetery or crematory
Location Miami Florida

18 (a) Funeral director John A. McCann
(b) Address 300 E. Baltimore St.

19 (a) Oct 15 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1947 at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1947 to Oct 14 1947 and that I last saw him alive on Oct. 14 1947.

Immediate cause of death Cardiac failure

	Duration
Due to Rheumatic carditis	
Due to	
Other Conditions Uremia (Antemortem kidney failure) (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul C. Manning M. D.
Address Bon Secours Hosp. Date signed 10/14/47

G56033

436931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G56033

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. H. (b) County
(c) City or town Enfield (If outside city or town limits, write RURAL and give town)
(d) Street No. Lake St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lurlene La Bounty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/3/38

8. AGE: Years	Months	Days	If less than one day
9	2	11	hr. min.

9. Birthplace Vermont (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Francis La Bounty
13. Birthplace Vermont

MOTHER 14. Maiden Name Irene Adams
15. Birthplace New Hampshire

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18-47 (month) (day) (year)
(c) Cemetery or crematory Locust Hurst
Location Enfield New Hamp.

18 (a) Funeral director John A. Wilson
(b) Address 360 E. Baltimore St.

19 OCT 15 1947 (b) Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1947 at 12.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1947 to 10/14 1947 and that I last saw h.e alive on 10/14 1947

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to AMASTOMOSIS BETWEEN RT. SUBCLAVIAN & PULMONARY ARTER	
Due to TETRALOGY OF FALLOT	46 S
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10 OCTOBER 1947

Major findings of operation: Tetralogy of Fallot

of autopsy: CARDIAC FAILURE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Clay M. D.
Address Johns Hopkins Hosp. Date signed Oct 16 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered 056034

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5600 Stonington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Hart

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	no	M	W	married

6 (b) Name of husband or wife Bessie M. Hart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1886

8. AGE: Years	Months	Days	If less than one day
61	4	27	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business Baltimore City

FATHER
12. Name James Hart
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Owens
15. Birthplace Virginia

16 (a) Informant Mrs. Harold F. Behrens
(b) Address 5600 Stonington Ave.

17 (a) Removal (b) Date thereof 10/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Carters Cem.
Location Deltaville, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 15 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13th 1947, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary occlusion
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William C. Hetfield M.D.
Medical Examiner.
Date signed Oct 14, 1947

G56035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13C

Reg. G56035 5245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 E. 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIVIAN BRAMMAN LEWIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	M.

6 (b) Name of husband ~~or wife~~ Porter Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1913

8. AGE: Years	Months	Days	If less than one day
34	1	29	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Walter H. Bramman
13. Birthplace St. Louis, Mo.

MOTHER
14. Maiden Name Regina Smith
15. Birthplace Baltimore, Md.

16 (a) Informant Comdr. Porter Lewis
(b) Address 300 E. 30th St (2W Woodrow Apts

17 (a) Burial (b) Date thereof 10/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 15 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1947 at 3:25 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1947 to Oct. 14 1947 and that I last saw h. alive on Oct 14 1947

Immediate cause of death	Duration
Pulmonary Tuberculosis bilateral, far advanced	2 yrs.
Due to	
Due to	
Other Conditions Amyloidosis far advanced	6 mos.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Vernon Langenheim M. D.
Address 715 Y. Charles St. Date signed Oct. 14 1947

VS 150

C56036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

C56036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 No Bentalow St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Singer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 75 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace Russia

MOTHER
14. Maiden Name Faunje
15. Birthplace Russia

16 (a) Informant Morris Singer
(b) Address 2037 N Bentalow St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-47 (month) (day) (year)
(c) Cemetery or crematory
Location Pikesville Herring Run

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Place

Date filed by registrar OCT 15 1947 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1947 at 7.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1947 to 10/14 1947 and that I last saw h[illegible] alive on 10/14 1947

Immediate cause of death: Brain Hemorrhage
Cerebral Decompensation — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hosp. Date signed 10/17/47

G56037

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. G56037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Valley & Preston Sts.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4315 Walther Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Thurman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 18-1860

8. AGE: Years	Months	Days	If less than one day
87	6	25	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Thurman
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Semmer
15. Birthplace Germany

16 (a) Informant Mrs. Joseph Thurman
(b) Address 4315 Walther Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road

19 (a) 10-15 1947 (Date rec'd by Registrar) (b) Thomas Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1947, at 11:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1947, to Oct 13 1947, and that I last saw him alive on Oct 13 1947.

Immediate cause of death	Duration
Edema Lungs	4 days
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 10/14/47

G56038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1952

G56038 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2321 N. Charles St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis Ryba

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Mildred Ryba
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) July 7, 1900

8. AGE: Years	Months	Days	If less than one day
47	3	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business

FATHER
12. Name Anton Ryba
13. Birthplace Bohemia

MOTHER
14. Maiden Name Anna Bekensky
15. Birthplace Bohemia

16 (a) Informant Mildred Ryba
(b) Address 2321 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Bruch & Son
(b) Address 900 N. Eutaw St

19 OCT 15 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1947, at 4 a. M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute edema of lungs.
Edema of brain.
Hypertrophy of heart.
History of alcoholism.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed 10-13-47

G56039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G56039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 China
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs.) mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 China
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Greer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/1884

8. AGE: Years	Months	Days	If less than one day
63	-	3	hr. min.

9. Birthplace Richmond Co, Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robert ?
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant James T. Holmes
(b) Address 820 China St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 N Montgomery St

OCT 15 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13/47 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5- 1947 to 10/13 1947 and that I last saw h alive on 19

Immediate cause of death
(a) Cly. Nephritis
Due to Uremia
(b) Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Klotz M. D.
Address 2 W Mt Royal Ave Date signed

VS 150

G56040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G56040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 5-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3614- Reisterstown Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LUDWIG NEWBERGER Newburger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/4/1871

8. AGE: Years 76 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Newburger
13. Birthplace Germany

MOTHER
14. Maiden Name Stern
15. Birthplace Germany

16 (a) Informant Mrs. Jacob Newburger
(b) Address 3614 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Baltimore, Maryland

18 (a) Funeral director David Sonderman & Son
(b) Address 902 Eutaw Place

OCT 15 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1947, at 1.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia; fractured ribs; Lacerations, head burns and abrasions

Due to

Other Conditions Chronic valvulitis, mitral and aortic; hypertrophy and dilitation of heart; Nephrosclerosis (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15/12

(a) Date of injury 10-12-47 9.30 p. M.
(b) Where did injury occur? Reisterstown & Ullman Ave Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pediastrian-struck by auto

23. Signature Howard J. Waldeck M.D. Medical Examiner.
Date signed 10-14-47

X

G56041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56041

48a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1338 Argyle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N-Y (b) County
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 323 Osborne St. Brooklyn (If rural give location) n/s
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha O Stapleton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife John Stapleton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1900

8. AGE: Years	Months	Days	If less than one day
47	5		hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name James Carr
13. Birthplace Md

MOTHER
14. Maiden Name Harriet Nichol
15. Birthplace Md

16 (a) Informant John Stapleton
(b) Address 323 Osborne St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Lee St

19 (a) Oct 15 1947 (Date acc'd by Registrar) (b) Interior for Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1947 at 7 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1947 to 10/13 1947 and that I last saw h. y. alive on Oct 13 1947

Immediate cause of death	Duration
Lobar Pneumonia	
Due to Common Cold	
Due to Influenza	
Other Conditions Cancer of Uterus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Wilkes M. D.
Address 601 N Calhoun Date signed 10/14/47

V. S 150

33a

G56042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G56042 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5500 Stonington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town write RURAL and give town)
(d) Street No. 5500 Stonington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar J. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary A Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20 - 62

8. AGE: Years 85 | Months 7 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Eastern Shore Md.
(State or county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Regan
15. Birthplace Md

16 (a) Informant Mrs Eugene R. Davis
(b) Address 5300 Stonington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/47 (month) (day) (year)
(c) Cemetery or crematory Hollyde Cem
Location Phila Pa

18 (a) Funeral director E. Wylie Lamarcar
(b) Address 4510 Liberty Hgts Ave

19 (a) 1947 (Date rec'd by registrar) Trenton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1947 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1942 to Oct 14 1947, and that I last saw him alive on Oct 14 1947

	Duration
Immediate cause of death: (a) Chronic Myocardial Degeneration	5 yrs
Due to: Arteriosclerosis	
Due to:	
Other Conditions: Chronic Nephritis Senility	5 yrs

(Include pregnancy within 3 months of death)

Date of operation No operation

Major findings of operation:

of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joshua H. Arnscott M. D.
Address 6419 Windsor Mill Road Date signed Oct 15 1947

VS 150

G56043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1180

G56043
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [redacted]
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Crest Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Koller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
45			min.

9. Birthplace Phila Pa
(Town, county, and state)

10. Usual Occupation merchant

11. Industry or business

FATHER
12. Name Nathan
13. Birthplace Austria

MOTHER
14. Maiden Name Zelda
15. Birthplace Austria

16 (a) Informant Sadie Koller
(b) Address 2210 Crest Ave

17 (a) Burial (b) Date thereof 10-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Har Nebo
Location Phila. Pa.

18 (a) Funeral director Jack Lewis Mc
(b) Address 260 Eastern Place

19 (a) [illegible] Turlington Williams M.D.
(Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14-1947, at 3 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Carbon Monoxide Poisoning
Conflagration.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-14-47? at ? M.
(b) Where did injury occur? 2210 Crest Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Undetermined

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/14/47

VS 181

X 119

G56044 — BALTIMORE CITY HEALTH DEPARTMENT — G56044

CERTIFICATE OF DEATH

X 477

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos.

2. USUAL RESIDENCE OF DECEASED: Queen Anne
(a) State Md. (b) County
(c) City or town Centreville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Centreville
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lloyd Tilghman Hayden — L. T. Hayden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 1879

8. AGE: Years 68 | Months 5 | Days 7 | If less than one day: hr. min.

9. Birthplace Centreville Md.
(Town, county, and state)

10. Usual Occupation Farm Manager

11. Industry or business

FATHER — 12. Name Isaac Hayden

13. Birthplace Md.

MOTHER — 14. Maiden Name Not Known

15. Birthplace

16 (a) Informant Catherine Richison

(b) Address R.F.D. Centreville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 17 1947 (month) (day) (year)

(c) Cemetery or crematory Chesterfield

Location Centreville, Md.

18 (a) Funeral director Barton Bros.

(b) Address Centreville, Md.

19 (a) Huntington Williams, Registrar
(Date rec'd by registrar)

OCT 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1947, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1947, to Oct 15 1947, and that I last saw h[illegible] alive on Oct 15 1947

Immediate cause of death: Carcinoma lung — Duration: 1 yr. (mo.)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 15 Thu 1947

Major findings of operation: Tumor lung - Biopsy & Carcinoma

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. V. D. Wack, M.D.

Address 513 E. 39th St Date signed Oct 15 1947

X

G56045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1482

G56045 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2915 Guilford ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2915 Guilford ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen McCauley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/19/1866

8. AGE: Years 81 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Andrew Reagan
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Brown
15. Birthplace Ireland

16 (a) Informant Mrs J Gantzbach
(b) Address 2915 Guilford ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Bayview Post

18 (a) Funeral director J. J. Gibbons Post
(b) Address 1318 Eutaw St.
(c) Huntington Williams M.D. Registrar
(Date rec'd by registrar) 10/15/1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/1947 at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to 10/12 1947, and that I last saw h alive on 10/11 1947.

	Duration
Immediate cause of death Myocardial Insufficiency	2 hrs.
Due to Myocarditis	6 mos.
Due to Arteriosclerosis	2 yrs.
Other Conditions Malignancy of Uterus (Carcinoma) (Include pregnancy within 3 months of death)	10 mos.

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard Mister M. D.
Address 532 E 22nd St Date signed 10/14/47

G56046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G56046
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 E Fort ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 E Fort ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie K. Bahleman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry W Bahleman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/21/1879

8. AGE: Years 68 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name Anthony Snyder
13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary Yeager
15. Birthplace Bayd Md.

16 (a) Informant Mr H W Bahleman
(b) Address 501 E Fort ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director D J Tobey Sons
(b) Address 308 Light St

19 (a) OCT 15 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/1947 at 1 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 19 to 10/14/1947 and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	1 week
Due to: Hypertension after stroke	
Due to: Diabetes Mellitus	2 years
Other Conditions Blindness. Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Muller M. D.
Address 124 S Dearborn St Date signed

VS 190

10 15 47.

G56047 BALTIMORE CITY HEALTH DEPARTMENT G56047
CERTIFICATE OF DEATH 61 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Concetta Guercio Valenza

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Valenza
13. Birthplace Italy

MOTHER 14. Maiden Name Nancy Santore
15. Birthplace

16 (a) Informant Joseph Valenza
(b) Address 1709 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Road

18 (a) Funeral director 2013 Joseph Tarasa dec
(b) Address 2013 Greenmount Ave

19 (a) 6 1947 (Date rec'd by registrar) (b) Lexington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13- 1947 at 5:39 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-47 19 to 10-13 1947, and that I last saw h alive on 10-13 1947.

Immediate cause of death: Diabetic Coma - | Duration 4 days
Due to Diabetes Mellitus -
Due to
Other Conditions Uterus Sclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Thomas M.D.
Address Med Arts Bldg M. D.
Date signed 10-15-47

VS 150

G56048 Exam Copy

39645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a

G56048
Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2546 Poff St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Edmendorf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anthony

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) 10-23-80

8. AGE: Years	Months	Days	If less than one day
67	11	22	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Adam Stitz

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Wright

15. Birthplace Md.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19th 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Leo G. Lesnick

(b) Address 1701-05 Druid Park Lake Ave Baltimore Md

OCT 15 1947 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1947, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1947 to Oct 14 1947, and that I last saw h alive on Oct. 14 1947.

Immediate cause of death Coronary Occlusion — Duration: sudden

Due to

Due to

Other Conditions Cholecystitis Acute

(Include pregnancy within 3 months of death)

Date of operation 14-Oct-47 (Anesthetic Death)

Major findings of operation: Autopsy no surgery performed

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Anesthetic Death
(b) Date of occurrence 14-Oct-47 at 3:45 P M
(c) Where did injury occur? Baltimore, Baltimore, Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No
(Specify type of place)
(e) Means of injury No injury

23. Signature James R. Cantwell M. D.
Address The Johns Hopkins Hospital Date signed

For O. St. Davis, by Howard J. Mellon, M.D.

G56049 Oct 68424 BALTIMORE CITY HEALTH DEPARTMENT ✓ G56049
CERTIFICATE OF DEATH 157E
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave.
(c) Hospital or institution: W. Balto. General Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wakeland David Marsh

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21 1947

8. AGE: Years | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Wakeland R. March Jr
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Jayne Brenner
15. Birthplace Balto Md

16 (a) Informant Wakeland R. March Jr
(b) Address 3000 Baker St.

17 (a) Burial (b) Date thereof 10-15-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.

OCT 15 1947
(Date rec'd by) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1947, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1947 to Oct 8 1947 and that I last saw h.m. alive on Oct 8 1947.

Immediate cause of death	Duration
CONGENITAL HEART	Since July
DISEASE CYANOTIC GROUP	21, 1947
Due to SAME.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph M. Lords M. D.
Address 813 N. Calvert St. Date signed 10/14/47
Baltimore, Md.

VS 150

G56050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Little Sisters of the Poor
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Monaghan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Wm. Monaghan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1867

8. AGE: Years	Months	Days	If less than one day
80	7	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name E. Baker
13. Birthplace

MOTHER
14. Maiden Name Mary Brown
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Ryba Weidefeld
(b) Address 900 Valley St.

19 (a) Date received by registrar (b) Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1947, at 2 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1947 to Oct 14 1947, and that I last saw her alive on Oct 13 1947

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North ave Date signed 10/14/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G56051 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 243 E. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 243 E. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Vance

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 76 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " " "

MOTHER
14. Maiden Name Julia Vance
15. Birthplace Va

16 (a) Informant Mrs Wofford
(b) Address 243 E. Central Ave

17 (a) Burial (b) Date thereof Oct. 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bennett Place
(c) Date rec'd by registrar OCT 15 1947 Pittington Williams, Registrar
(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1947, at 8:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive - Arteriosclerotic
Cardio-Renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 10/17/47

G56052 | BALTIMORE CITY HEALTH DEPARTMENT ✓ | G56052 Registered No.

437725

CERTIFICATE OF DEATH 61

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 554 Conway St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Norris

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	col	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/87

8. AGE: Years	Months	Days	If less than one day
60	3	10	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Crockett
13. Birthplace Va

MOTHER
14. Maiden Name Emily ?
15. Birthplace ? Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17. 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.,
Location Brooklyn Md

18 (a) Funeral director Elizz O. Wilson
(b) Address 1000 Bentley Ave

19 (a) (Date rec'd by registrar) (b) Registrar
OCT 15 1947 Remington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1947, at 1.35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1947 to 10/14 1947, and that I last saw her alive on 10/14 1947.

Immediate cause of death Cerebral Haemorrhage. Possible hypostatic pneumonia — Duration 3 weeks 3 days
Due to Arteriosclerosis and Hypertension — More than 6 weeks
Due to
Other Conditions Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Grob M. D.
Address 1 Hit Date signed 10/17/47

83a

G56053 #11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1947

Registered No. G56053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
45(?)			hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace Unknown

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY OCT 15 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 15 1947 (Date rec'd by registrar) (Signature of Registrar) Huddleston Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1947, at 9:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury found 9-29-47 at 8:45 P M(?) 2515
(b) Where did injury occur? Found: Curtis Creek
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? no
(d) Means of injury Found Drowned

23. Signature Earl F. Royer M.D. Medical Examiner.

Date signed 9-30-47

G56054 — 10th B 91167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 160a — Registered No. G56054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1530 West fair mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 West Fair Mount
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Dorrest Vernon Moore

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10, 1947

8. AGE: Years	Months	Days	If less than one day
			18 hr. 10 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name Morris Moore
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Dorothy Crawford
15. Birthplace Ellington South Carolina

16 (a) Informant Dorothy Crawford Moore
(b) Address 1530 West Fairmount

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 14 1947

18 (a) Funeral director Commissioner of Health
(b) Address Huntington Hillman M.D.

OCT 15 1947 (Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1947, at 7:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 10 1947, to October 10 1947, and that I last saw him alive on OCT 10, 1947.

Immediate cause of death	Duration
atelectasis	
Due to sluggish respirations at birth.	
Due to intracranial hemorrhage?	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Norman L. Leeman M. D.
Address University Hosp Date signed 10/11/47

X

G56055 Alt B-90115 V

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. G56055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution: SINAI
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto - Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 E. Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Girl Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: wht | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
2 hrs			2 hrs. min.

9. Birthplace Balto - Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Paul H. Cunningham
13. Birthplace VA.

MOTHER — 14. Maiden Name Genevieve Kidd
15. Birthplace Balto - Md.

16 (a) Informant Mrs. Genevieve Cunningham
(b) Address 2329 E. Jefferson St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

(c) Filed (Date received by registrar) (d) Registrar

OCT 15 1947

Commissioner of Health

VS 150 . . . 4

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-25 1947, at 1 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-25 1947 to Sept-25 1947 and that I last saw her alive on Sept 25 1947

Immediate cause of death — Duration

Due to ABDOMINAL PREGNANCY

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sydney Lewis M. D.
Address Lewis Hosp. Date signed

G56056 DC# B 88886 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G56056

TN. 113846 CERTIFICATE OF DEATH 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 McCulloh St. Zone 17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Johnson (Mary

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Girl
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16/ 1947

8. AGE: Years | Months | Days: 7 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Carter
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace N. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Cremated (b) Date thereof 9-23/47
(Burial, cremation, removal) (month) (day) (year)
(c) Cemetery or crematory Balto City Hosp
Location 4940 Eastern Ave

18 (a) Funeral director Balto City Health Dept
(b) Address 4940 Eastern Ave

19 (a) (b)
(Date received by Registrar) Registrar

OCT 18 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23/ 1947 at 11.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16/ 1947 to Sept 23 1947 and that I last saw h er alive on Sept 23/ 1947

Immediate cause of death — Duration

Prematurity — 7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosps Date signed Sept 23 1947

G56057 BM G 90500 CWK-114137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G56057

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Carson Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl-Haskins, (Irene)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 27-1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Prunell Haskins
13. Birthplace Maryland

MOTHER
14. Maiden Name Irene Whitton
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9-30-47 (month) (day) (year)
(c) Cemetery or crematory Balto. City Hosp
Location 4940 Eastern Ave

18 (a) Funeral director Balto. City Hosp.
(b) Address 4940 Eastern Ave.

1947 OCT 16 (Date rec'd by registrar) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1947, to Sept. 28 1947, and that I last saw her alive on Sept. 28 1947.

Immediate cause of death: Prematurity — Duration: 1 day
Due to:
Due to:
Other Conditions: Atelectasis — 1 day

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Prematurity, Patent septum cardiac

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosps. Date signed Sept 30. 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56058 Blk B 89253 JL - 113858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G56058

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Young - Margaret

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Hibb
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Young
15. Birthplace Md.

16 (a) Informant B. C. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9-24-47 (month) (day) (year)
(c) [illegible] or crematory Balto. City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

OCT 16 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1947, at 3.15AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1947 to Sept. 17 1947 and that I last saw h im alive on Sept. 17 1947.

Immediate cause of death	Duration
Prematurity	1 day
Due to	
Due to	
Other Conditions Atelectasis	1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity, Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian L. Griffin M. D.
Address Balt City Hosp. Date signed 27 X 1947

G56059 DCT 90484 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G56059

CM. 114141

CERTIFICATE OF DEATH

160a

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 243 Douglass CT.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Johnson (Doris)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28 -1947

8. AGE: Years | Months | Days: 6 | If less than one day: hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Norman Johnson
13. Birthplace MD.

MOTHER
14. Maiden Name Doris Rose
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Crematory 9.00AM (b) Date thereof 10-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ or crematory Balto. City Hospitals
Location 4940 Eastern AVE.

18 (a) Funeral director
(b) Address

19 (a) OCT 6 1947 (b) Thurston Forr Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. -4- 1947, at 4.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1947, to Oct. 4- 1947, and that I last saw h[e] alive on Oct. 4 - 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 7days
Due to:
Due to Prematurity — 7days
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosp. Date signed 7 Oct 1947

Hospital Disposal

G56060 B24 B 90889 AB-114330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157B

Registered No. G56060

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 Sisson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Allman

3 (b) If veteran, name war

3 (c) Social Security Account No:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 7-1947

8. AGE: Years	Months	Days	If less than one day
			hr. 5 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Morrison Allman
13. Birthplace ?

MOTHER
14. Maiden Name Helen Bowen
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) 9.00AM (b) Date thereof 10-9-47 (month) (day) (year)
(c) Cemetery or crematory Balto. City Hospitals
Location 4940 Eastern AVE.

18 (a) Funeral director
(b) Address

19 (a) OCT 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7- 19 47, at 9.55A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7-47 19 47 to 10-7- 19 47 and that I last saw h. er alive on 10-7- 19 47

Immediate cause of death Paralysis — Duration Lost

Due to Complete myelo meningocele

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Ahern M. D.
Address Balto. City Hospitals Date signed 10-7-47

VS 150 Hospital Disposal

G56061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56061

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 Dukeland St
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2002 Dukeland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME R Herbert Gregory.

3 (b) If veteran, name war

3 (c) Social Security Account No. 7 2 - 28 - 425

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Louise Nelson Gregory

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July 30th 1873

8. AGE: Years 74 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Caroline Co. Va. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Sales Agent

FATHER 12. Name Dr. Richard R. Gregory

13. Birthplace Unknown

MOTHER 14. Maiden Name Melevine Crutchfield

15. Birthplace Unknown

16 (a) Informant Mrs. Louise N. Gregory

(b) Address 2002 Dukeland St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/16/47 (month) (day) (year)

(c) Cemetery or crematory Ashland

Location Hanover Co. Va.

18 (a) Funeral director William Cook Inc.

(b) Address 217 St. Paul St.

19 (a) OCT 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1947 to Oct 14 1947 and that I last saw him alive on Oct 14 1947.

Immediate cause of death: Bronchi-pneumonia — Duration 3 days

Due to

Due to

Other Conditions advanced arteriosclerosis ? Myocarditis about 2 mo. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter D. Tufft M. D.

Address 22 20 Harrison Blvd Date signed Oct 15/47

VS 150

G56062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12-1a

G56062 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6-4
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 N. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bertha Ackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband William Ackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30 1896

8. AGE: Years 50 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name William Detloof
13. Birthplace Germany

MOTHER
14. Maiden Name Annie (Unknown)
15. Birthplace Germany

16 (a) Informant William Ackoon
(b) Address 431 N. Washington St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/16/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 16 1947 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1947, at 4:45 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 11 1947 to Oct 13 1947 and that I last saw h[illegible] alive on Oct. 13 1947

Immediate cause (a) Acute Cardio-vascular Decompensation
(b) Chr. Nephritis with Hypertension
Due to
Other Conditions Dyspnea
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: (a) ? (b) ? (c)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. L. Semmes
Address 700 E. Pratt St Date signed 10/15/47

VS 150

C56063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

116

Registered No. C56063

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 41 44th & UNIV. PARKWAY (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** JAMES WALLACE FOLGER

3 (b) If veteran, name war: N

3 (c) Social Security Account No. 217-05-2384

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife FLORENCE FOLGER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20th 1902

8. AGE: Years 45 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace COLORADO (Town, county, and state)

10. Usual Occupation FURNITURE MANUFACTOR

11. Industry or business

FATHER
12. Name HONZO TREZEVANT
13. Birthplace EASLEY S. CAROLINA

MOTHER
14. Maiden Name ESSIE RUSSELL
15. Birthplace EASLEY S. CAROLINA

16 (a) Informant FLORENCE FOLGER
(b) Address TUDOR ARMS Apt. BALTO

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/17/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 16 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1947, at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 12 1947, to October 15 1947, and that I last saw him alive on October 15 1947.

Immediate cause of death	Duration
Bilateral lobar pneumonia	2 days
Due to mediastinitis	3 days
Due to Ruptured esophagus	3 days
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. C. Jimmy M. D.
Address Union Memorial Hosp. Date signed 10-15-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G56064

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Stafford Hotel
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Stafford Hotel (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob L. Goldstein

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lillie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Libbie
15. Birthplace Russia

16 (a) Informant Leonard Grunit
(b) Address Stafford Hotel

17 (a) Burial (b) Date thereof 10-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Cem
Location Rogers Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2600 Eutaw Place

19 (a) OCT 16 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14-1947 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1932 to Oct 14 1947 and that I last saw h[illegible] alive on Oct 14 1947

Immediate cause of death myocardial infarction — Duration 6 days

Due to arteriosclerosis — Duration 10 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lewis Silkstone
Address 1720 Eutaw Pl. Date signed Oct 15/47

V S 150

G56065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓

Registered No. G56065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2925 Violet ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Lambert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mathew
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Ida Lambert
(b) Address 2925 Violet ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-47 (month) (day) (year)

(c) Cemetery or crematory
Location Netzer-Mt Carmel

18 (a) Funeral director Jack Levin Inc
(b) Address 2660 Eutaw Place

19 (a) OCT 16 1947 (b) Registrar [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1947 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to Oct. 15 1947, and that I last saw h[illegible] alive on Oct. 15 1947

Immediate cause of death: Subarachnoid hemorrhage — Duration: 7 hours

Due to: Hypertension (?) — Duration: over 4 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Goldstein M. D.

Address UBGHH Date signed Oct. 15, 47

VS 150

G56066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56066

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3214 Lynhurst Ave (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Euginie Bacharach

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Sigmund

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 72

8. AGE: Years 75 | Months | Days | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Germany

MOTHER
14. Maiden Name Sophie
15. Birthplace Germany

16 (a) Informant Walter Lamplugh
(b) Address 3214 Lynhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-47 (Month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2 [illegible] Eutaw Place

19 (a) OCT 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15, 1947 at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1947 to Oct 15, 1947, and that I last saw her alive on Oct 15 1947.

Immediate cause of death ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE WITH FAILURE — Duration

Due to

Due to

Other Conditions COMMON DUCT STONE

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Susman M.D.
Address Sinai Hosp Date signed 10/16/47

G56067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

Registered No. G56067

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 E Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 E Preston St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Josephine H. Brown

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Jacob H Brown
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 1863

8. AGE: Years 84 | Months 1 | Days 19 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Md

MOTHER
14. Maiden Name Charlotte Twenty
15. Birthplace Md

16 (a) Informant Mrs Josephine Maxwell (daughter)
(b) Address 1614 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Catonsville Md

18 (a) Funeral director Robert E Williams
(b) Address 1515 McCulloh St

19 (a) OCT 16 1947 (Date received by registrar) (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1947, at 8:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1947 to Oct 13 1947, and that I last saw h.. alive on Oct 13 1947.

	Duration
Immediate cause of death: Pulmonary Edema	Oct 12-13
Due to: Pulmonary Infarction	1947
Due to:	
Other Conditions: Chronic Myocarditis Arteriosclerosis Nephritis	Complete

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph L Young, M.D.
Address 1424 E Monument St Date signed 10/18/47

G56068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G56068

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 714- W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM B. MIERHAUS

3 (b) If veteran, name war: W. W. #1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of ~~husband~~ or wife: Lillie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Cabinet Maker
11. Industry or business

FATHER
12. Name: John Mierhaus
13. Birthplace: Germany

MOTHER
14. Maiden Name: Frances Balhorne
15. Birthplace: Germany

16 (a) Informant: Mrs. Anna Marshall
(b) Address: 2105 Chilcoa Terrace

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/18/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ U.S. National
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) OCT 16 1947 (Date rec'd by registrar) (b) Huntington Pallbearers Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1947, at 8.55 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Syphilitic aortitis
Due to: Myocardial hypertrophy, dilatation, and degeneration.
Other Conditions: Acute pulmonary edema. Pulmonary tuberculosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George L. Merrill M.D. Medical Examiner.
Date signed 10-15-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4 Cert's

G56069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56069

City 112442

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2543 N. Howard ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Cole

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Janie Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4- 1881

8. AGE: Years	Months	Days	If less than one day
65	10	9	hr. min.

9. Birthplace VA. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Cole
13. Birthplace VA.

MOTHER
14. Maiden Name Eliza Howard
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Peter E. Walsh
(b) Address 1515 McElderry St

19 (a) OCT 16 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13- 1947, at 5.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24- 1947 to Oct. 13 1947 and that I last saw h im alive on Oct. 13- 1947.

	Duration
Immediate cause of death Bilateral Fac Edema and Pulmonary Tuberculosis of Lungs	2½ yrs
Due to	
Due to	
Other Conditions Cerebro Vascular Disease Cardio Vas Dis	2 Days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sergt W. Parks M. D.
Address Balt City Hosp Date signed 10-14-47

G56070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56070 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 732 W. Cross St
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 732 W. Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Denninger

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-5248

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14. 1869

8. AGE: Years	Months	Days	If less than one day
78	0	0	hr. min.

9. Birthplace Baltimore md (Town, county, and state)
10. Usual Occupation Examiner
11. Industry or business Pagamas

FATHER
12. Name John Denninger
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Estelle Stephey
(b) Address 113 Mallow Hill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Wm F. Porter
(b) Address 2836 W. North ave

19 (a) OCT 16 1947 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14th 1947, at 5.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1947 to Oct. 14 1947 and that I last saw h-er alive on Oct. 14 1947.

Immediate cause of death	Duration
Myocarditis	3yr
Due to Hypertension	5 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged Statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harry F. Kates, M.D.
Address 517 Scott St Date signed 10/16/47

VS 2

X

File 056071 BC# F99109 115c

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered 056071

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 N. Broadway
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena.
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Master Roger Lee Brittingham

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1944

8. AGE: Years	Months	Days	If less than one day
3	6	028	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Mr. Edward Lee Brittingham
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mrs. Estella Mae Conroe
15. Birthplace Baltimore, Md.

16 (a) Informant EDWARD L. BRITTINGHAM
(b) Address PASADENA, MD.

17 (a) Burial (b) Date thereof 10-18-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 OCT 16 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1947, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1947 to Oct. 14 1947, and that I last saw him alive on Oct. 14, 1947 3:00 P.M.

Immediate cause of death Cessation of breathing on operating table — due to thyoma: lymphatisma — Duration —
Due to —
Due to —
Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation Oct 14, 1947
Major findings of operation: Hypertrophied tonsils.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence 10/14/47 at 2:45 P.M.
(c) Where did injury occur? Church Home Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No
(Specify type of place)
(e) Means of injury Operation (Doctor)
23. Signature Richard M. Barnett
Address Church Home + Hosp. Date signed 14 Oct 47

J.R. Davo-

X Howard J. Malden, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56072

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 851 S. Paca St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 851 S. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LUTHER KUHLMAN COVELL

3 (b) If veteran, name war: None

3 (c) Social Security Account No. ?

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie May Covell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1887

8. AGE: Years 60 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joel O. F. Covell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary M. Mohr
15. Birthplace Balto. Md.

16 (a) Informant Miss Mary M. Covell
(b) Address 851 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/47 (month) (day) (year)
(c) Cemetery Loudon Park
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17. Md.

19 (a) OCT 16 1947 (Date received by registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1947, at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to 15 Oct. 1947 and that I last saw him alive on 15 Oct 1947

Immediate cause of death	Duration
Cardio-Vascular Renal Disease	
Due to Arteriosclerosis	1 Year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: NO
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward L. Mclean M.D.

Address 682 Washington Blvd Date signed 15 Oct 47

G56073
JL - 96769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56073

The following items of information should be carefully supplied. Every item is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 N. Rose St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Vitak

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 28, 1884

8. AGE: Years	Months	Days	If less than one day
63	4	16	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation City Employee
11. Industry or business

FATHER
12. Name Frank Vitak
13. Birthplace [illegible] Czechoslovakia

MOTHER
14. Maiden Name Mary Klima
15. Birthplace [illegible] Czechoslovakia

16 (a) Informant Louise Vitak (wife)
(b) Address 907 North Rose Street, Zone 5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03-05 E. Madison Street.

19 (a) OCT 16 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1947, at 2.35PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1945 to Oct. 13 1947, and that I last saw him alive on Oct. 13 1947.

Immediate cause of death	Duration
Congestive Heart Failure	2-3 mo
Due to Arteriosclerotic Cardio Vascular Dis	20 yrs
Due to	
Other Conditions Pulmonary Tuberculosis (Include pregnancy within 3 months of death)	10 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. E. C. Parker M. D.
Address Bel Air, Md. Date signed 10-14-47

VS 150

937

G56074

BALTIMORE CITY HEALTH DEPARTMENT

LW 114302

CERTIFICATE OF DEATH

93D

Registered No. G56074

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Willis Edwards

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Annie Edwards
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25- 1884

8. AGE: Years	Months	Days	If less than one day
62	9	29	hr. min.

9. Birthplace Fla.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Oct. 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Cemetery
Location Arbutus Md.

18 (a) Funeral director Henry O. Wilson
(b) Address 1017 Broadway ave

19 (a) OCT 16 1947 (b) Washington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14- 1947, at 2:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1947 to Oct. 14 1947, and that I last saw him alive on Oct. 14 1947.

Immediate cause of death	Duration
Cerebral-vascular accident	1 week
Due to Arteriosclerotic Hrt. Disease & generalized	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert A. Farber M. D.
Address Balto City Hosps Date signed 10-15-47

G56075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G56075 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Resident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 1/2 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jobe Roane

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	N	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/29/04

8. AGE: Years	Months	Days	If less than one day
43	-	13	hr. min.

9. Birthplace Essex Co. Va. (Town, county, and state)

10. Usual Occupation Long Shoreman

11. Industry or business

FATHER
12. Name Harrison Roane.
13. Birthplace Essex Co., Virginia.

MOTHER
14. Maiden Name Fannie Roane
15. Birthplace Essex Co. Virginia

16 (a) Informant Fannie Lipscomb
(b) Address 906 1/2 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3947 Schroeder St

19 OCT 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1947 at 8:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1947 to 10/12 1947, and that I last saw h.e. alive on 10/12 1947.

Immediate cause of death Lobar Pneumonia — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Hunt M.D.

Address 1514 Division Date signed 10/15/47

G56078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G56078

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 Allendale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Allendale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma L. Heise

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Charles P. Heise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1876

8. AGE: Years	Months	Days	If less than one day
71	5	19	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Margaret F. Ziesberg
(b) Address 710 Allendale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17,1947 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. W. Ramsburg
(b) Address 4510 Liberty Heights Ave.

19 (a) [illegible] Washington Williams, M.D.
(Physician or coroner)
VS Oct 16 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1947 at 12.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1947 to Oct. 14 1947.
and that I last saw h. alive on Oct. 14 1947.

Immediate cause of death: Hemorrhage of brain — Duration: 4 days
Due to: Hypertension
Due to: Old age
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. B. Mayo M. D.
Address 516 Cathedral St. Date signed 10-16-47

C56077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. C56077

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Cross out words not applicable. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74? years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Shehan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John W. Shehan

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) 9-6-?

8. AGE: Years	Months	Days	If less than one day
About 72?	1	9	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Patrick Henney
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Bailey
15. Birthplace Ireland

16 (a) Informant Katherine Heavey
(b) Address 1612 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director H. W. Macks and Son
(b) Address 805 N. Calvert Street

19 (a) OCT 16 1947 (Registrar) (b) Huntington Williams M.D. Registrar

ADDRESS GIVEN BY Katherine Heavey
DATE GIVEN BY Mrs. Heavey

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1947 at 9:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1947 to 10-15 1947 and that I last saw her alive on 10-14 1947

Immediate cause of death Hypostatic pneumonia — Acute intestinal obstruction

Due to Due to carcinoma of the rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Joseph Krejci M. D.
Address 1400 N. Carolina St. Date signed 10-15-47

G56078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

Registered No. G56078

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013- Plum Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELNORE LOUIS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/10/13

8. AGE: Years	Months	Days	If less than one day
34	5	5	hr. min.

9. Birthplace RICHMOND, VA.
(Town, county, and state)
10. Usual Occupation HOUSE WORER
11. Industry or business

FATHER
12. Name WILLIAM LOUIS
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name ELLA BRADSHAW
15. Birthplace RICHMOND, VA.

16 (a) Informant BESSIE HILL
(b) Address 1855 W. MORE ST - Rich. VA.

17 (a) BURIAL (b) Date thereof 10-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Richmond, Va

18 (a) Funeral director Charles D. Law
(b) Address 602 Madison Ave.

19 (a) OCT 16 1947 Thurlington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1947, at 8.40 a M

21. I certify that I took charge of the remains described above, held an Insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to hop death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. Merrill M.D.
Medical Examiner.
Date signed 10-15-47

VS 151

correct age is especially important. Physicians: please write the c
the causes of death clearly and legibly.

G56079

BALTIMORE CITY HEALTH DEPARTMENT

Bch B-91020 CERTIFICATE OF DEATH V159

G56079
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Street
(c) Hospital or institution: St. Joseph's Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Stockton Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Geraldine Michaeline Goodman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1947

8. AGE: Years | Months | Days: 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Michael Francis Goodman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Florence Mary Sherry
15. Birthplace Harrisburg, Pa.

16 (a) Informant Florence Mary Goodman
(b) Address 1200 Stockton Ave.

17 (a) Burial (b) Date thereof 10/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Govans Mill Rd.

18 (a) Funeral director M. J. DeFrancis & Sons
(b) 1808 Eastern Ave.
(Address)

19 (Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16, 1947, at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7, 1947 to Oct 16, 1947, and that I last saw her alive on Oct 16, 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Hemorrhagic Diathesis	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

Of autopsy: Not Done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F. DiPaula, M.D.

Address St. Joseph's Hosp. Date signed 10/16/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G56080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G56080
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore- Patapsco Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Miland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM SUGGS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1910

8. AGE: Years	Months	Days	If less than one day
37	6	5	hr. min.

9. Birthplace Estate Carolina
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Sand & gravel

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Mary Reed
(b) Address 6001 Edgewood Rd.

17 (a) Burial (b) Date thereof Oct. 16, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. F. Hyllop
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.
Registrar

OCT 16 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1947, at 11.30 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Gastro-enteritis
Hypertrophy + dilatation of Heart
Acute Congestion + edema of lungs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 10-13-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G56081

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3034 Hudson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3034 Hudson Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Kabernagel

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-16-5517

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Sarah E. Hildebrandt
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Dec. 1885

8. AGE: Years: about 61 | Months: 10 | Days: | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Boiler-maker
11. Industry or business

FATHER
12. Name ? Kabernagel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Herman H. Kabernagel (Son)
(b) Address 3034 Hudson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore, Cemetery
Location E. North Ave. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1947 at 6:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1947 to Oct 14 1947, and that I last saw h[illegible] alive on Oct 14 1947.

Immediate cause of death: Cardiac Cachexia — Duration: 6 wks.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Hebert L. Hunt M.D.
Address 1016 S. East Ave. Date signed 10/15/47

G56082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G56082

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 N. Decker Ct
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N. Decker Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Cortes

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Benjamin F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22 1872

8. AGE: Years 75 | Months 5 6 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name James Barnes
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Dorman
15. Birthplace Balto. Md.

16 (a) Informant Elizabeth Bornheimer
(b) Address 20 N. Decker Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-17-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John A. Higgins
(b) Address 3060 E. Balto. St

19 (a) OCT 16 1947 (Date rec'd by registrar) (b) [illegible] for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] to Oct 14 50, and that I last saw h[illegible] alive on Oct 14 1947

Immediate cause of death: Senility — Duration
Due to: Carcinoma of Uterus
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2436 E Balto Date signed 10-16-47

V S 150

G56083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 B

G56083 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 827 N Eutaw
(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 N. Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Frederick Grasser

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 212-10-6538

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Florence B Grasser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31 1884

8. AGE: Years 63 | Months 1 | Days 15 | If less than one day: hr. min.

9. Birthplace Albany N. Y.
(Town, county and state)

10. Usual Occupation Piano Salesman

11. Industry or business

FATHER
12. Name Frederick Grasser
13. Birthplace Albany N.Y. Germany

MOTHER
14. Maiden Name Lena Rubinson
15. Birthplace Germany

16 (a) Informant Florence B. Grasser
(b) Address 827 N. Eutaw St Balto

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct. 18-47 (month) (day) (year)
(c) Cemetery or crematory Kriders
Location Carroll Co.

18 (a) Funeral director J. F. Elena & Sons
(b) Westminster Md.

19 (a) (Date rec'd by registrar) OCT 18 (b) Huntington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16th 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1947, to Oct 16 1947, and that I last saw h[illegible] alive on Oct 9 1947.

Immediate cause of death: Cancer of stomach. — Duration: 11 Months

Due to

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation 9/8/1947.

Major findings of operation: Cancer of stomach with metastases throughout abdomen.

of autopsy

PHYSICIAN

Underline the one to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry D. McCarty

Address 37 W. Preston St Date signed 10/16/47

VS 180

656084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 656084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 S Clinton Street
(c) Hospital or institution Veterans Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Parkville
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9021 Harford Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Einemacher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Emily

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7-1856

8. AGE: Years	Months	Days	If less than one day
90	10	8	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Helen Faulkis
(b) Address 2238 Lake Avenue

17 (a) Burial (b) Date thereof 10/18/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lakewood
Location Balto

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road.

19 (a) (b) Thurlington Williams
Registrar

OCT 16 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15 1947, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 1945 to 10/15 1947.
and that I last saw h[illegible] alive on 10/15 1947.

Immediate cause of death	Duration
Carcinoma of Liver	4 yrs.
Due to	
Due to Carcinomatosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Damian P. Magin M. D.
Address 3376 Frederick Ave Date signed 10/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G56085 **CERTIFICATE OF DEATH** 13B Registered G56085

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 W. Lombard St. (If rural-give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred V. Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1913

8. AGE: Years 33 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace West Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Benj. (Whittington)
13. Birthplace Virginia

MOTHER 14. Maiden Name Lena Posey
15. Birthplace W. Va.

16 (a) Informant Frank L. Thomas
(b) Address 1122 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton, Ave. & Fayette St.

19 (d) OCT 16 1947 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1947 at 8:00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947 to Oct. 15 1947, and that I last saw her alive on Oct 14 1947

Immediate cause of death Pulmonary Tuberculosis — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen M. D.

Address 206 S. Gilmor St. Date signed 10.16.47

VS 150

X

656086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. 656086

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. South Rolling Rd. & Newberry Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM C BLUM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ada R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-31-1863

8. AGE: Years 84 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Bluem
13. Birthplace Md

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mary M. Tennyson
(b) Address Ridgeway Rd Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-47 (month) (day) (year)
(c) Cemetery or crematory Catonsville
Location Baltimore Md

18 (a) Funeral director Geo. A. Fuhrman
(b) Address Catonsville Md

19 OCT 16 1947 Huntington Williams Md (Date rec'd by registrar) REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1947, at 4.05 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial hypertrophy and degeneration

Due to Acute pulmonary edema.

Other Conditions Cirrhosis of liver. Arteriosclerosis.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature 10-15-47 Lloyd L. Merrill M.D. Medical Examiner.
Date signed

VS 181

Please write plainly, preferably in ink. Use one square for each letter or figure. Be sure to give the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

G56087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 124 B

Registered No. G56087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 20 days
(e) Length of stay in Baltimore (yrs., mos., or days): 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Pa. (b) County: Upper Darby
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: Apt. 304 Long Lane Court (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3 (a) FULL NAME: Rubie Duckworth Kane

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: Frederick T. Kane
6 (c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): May 19, (1897)

8. AGE: Years	Months	Days	If less than one day
51 (52)	5	28	____ hr. ____ min.

9. Birthplace: Charlotte, NC (Town, county, and state)
10. Usual Occupation: Housf
11. Industry or business:

FATHER
12. Name: Henry D. Duckworth
13. Birthplace: NC

MOTHER
14. Maiden Name: Mary Severs
15. Birthplace: NC

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/17/47 (month) (day) (year)
(c) Cemetery or crematory: Arlington Nat'l.
Location: Arlington, Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 1947, 4:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1947 to Oct. 16 1947, and that I last saw her alive on Oct. 16 1947.

Immediate cause of death	Duration
(1) Cirrhosis of liver with marked fatty changes	yrs ?
(2) Postoperative state. Due to hysterectomy (a) dilatation of intestine (paralytic ileus	3 days
Due to (b) Bronchopneumonia, patchy	3 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 10/16/47

X

G56088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2306 Frederick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Frederick Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3 (a) FULL NAME Ernest August Otriede

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-05-2821

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Annie M. Otriede
6 (c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): July 12, 1881

8. AGE: Years 66 | Months 3 | Days 3 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, state)
10. Usual Occupation: Night Watchman
11. Industry or business: Ives Co.

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Annie M. Otriede
(b) Address: 2306 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-47 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore, Md.

18 (a) Funeral director: George L. Sykes
(b) Address: 2101 Frederick Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar

OCT 16 [illegible] Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1947, at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 19 47 to Oct 15 19 47 and that I last saw h[illegible] alive on May 14 19 47

Immediate cause of death: Hypertensive cardiovascular renal disease — Duration: 6 mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Albert H Katz
Address 2030 Wood Ave Date signed Oct 16, 1947

X

G56089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56089 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and name town)
(d) Street address Gardner Well College (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Bradburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Charles W.

6 (c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): 12-8-23

8. AGE: Years: 23 | Months: 10 | Days: 7 | If less than one day: hr. min.

9. Birthplace: N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: J.B. Painter

13. Birthplace: N.C.

MOTHER 14. Maiden Name: Ella Prestley

15. Birthplace: N.C.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14 47 (month) (day) (year)

(c) Cemetery or crematory

Location Lyford N.C.

18 (a) Funeral director: John E. Mitchell Homes

(b) Address: 1900 Eutaw Place

19 (a) [illegible] (b) Registrar's signature for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-15 1947 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27-47 to 10-15 1947 and that I last saw her alive on 10-15 1947

Immediate cause of death: [redacted] cardiac failure — Duration: 5-6 mo

Due to: Neuroblastoma

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Lorena Spencer M.D.

Address: Johns Hopkins Hosp. Date signed 10-16-47

VS 150

C56090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. C56090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Altoona
(If outside city or [illegible], write RURAL and give town)
(d) Street No. 1714- 13th Street
(If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE W. HESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-22-1907

8. AGE: Years	Months	Days	If less than one day
40	3	22	hr. min.

9. Birthplace Hooversville, Penna.
(Town, county, and state)

10. Usual Occupation Merchant Seaman

11. Industry or business

FATHER
12. Name Harry H. Hess
13. Birthplace Hooversville, Penna.

MOTHER
14. Maiden Name Catherine Smeltzer
15. Birthplace Hooversville, Penna.

16 (a) Informant Miss Bernice Hess
(b) Address Altoona, Penna.

17 (a) Removal (b) Date thereof 10-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Rosehill
Location Altoona, Penna.

18 (a) Funeral director Wm. J. Tierney & Sons
(b) Address N. Logan Ave; Altoona, Pa.

19 (a) [illegible] Washington Williams
(Signature of registrar)

OCT 17 1947
VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1947, at 2 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/14/47 at about 11 a M. 3/2
(b) Where did injury occur? Harbor Foot Broad St Pier
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/16/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V163H

Registered No. G56091

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111- N. Collington Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NORMA WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Howard A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11 1928

8. AGE: Years 19 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Open Lithography

FATHER
12. Name Philip Rhinehardt
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary Unknown
15. Birthplace Baltimore Md

16 (a) Informant Howard A. Williams
(b) Address 1754 E North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Gilbert Lee Fox
(b) Address 2147 E Monument St

19 (a) Date rec'd by registrar OCT 17 1947 Signature for Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16, 1947, at 2.15 P M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Carbon monoxide poisoning

Due to illuminating gas.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-16-47 at about 1 a. M.
(b) Where did injury occur? 1111 N. Collington Ave. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 4 burners on stove unlit- illuminating gas

23. Signature Howard J. Bucci M.D.
Medical Examiner

Date signed 10-16-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12.2a

Registration No. G56092

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Hilla St.
(If rural give location)
(e) Citizen of foreign country? Cur (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian F. Curren

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M, W

6 (b) Name of husband or wife Joseph Curren
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1883

8. AGE: Years	Months	Days	If less than one day
63	11	29	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Moran
13. Birthplace

MOTHER
14. Maiden Name Roberta King
15. Birthplace

16 (a) Informant Mrs Pernilla Curren
(b) Address 3510 Hilla St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

OCT 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1947, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1947 to Oct 16 1947, and that I last saw her alive on Oct 16 1947.

Immediate cause of death	Duration
Coma	
Due to Diabetic Acidosis	24 h.
Due to Diabetic Nephritis	?
Other Conditions Arteriosclerosis Cerebral Hemorrhage (Include pregnancy within 3 months of death)	2 yr.

Date of operation Right frontal burr hole
Major findings of operation Arteriosclerosis, cerebral hemorrhage
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Schaffer M. D.
Address Mercy Date signed 10-16-47

VS 150

G56093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 Registered No. G56093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Gen Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town) Govans
(d) Street No. 1637 Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Effie A. Harrison

3 (b) If veteran, name war
3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or~~ divorced. Married

6 (b) Name of husband or wife Richard S. Harrison
6 (c) If alive, give age years

20. DATE OF DEATH Oct 15 1947, at 8:47 M

7. Birth date of deceased (mo., day, yr.) Sept 26 1896

8. AGE: Years 51 | Months 0 | Days 19 | If less than one day ..... hr. ..... min.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

9. Birthplace Tilghmans Md. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William Cummings
13. Birthplace Tilghmans Md.

MOTHER
14. Maiden Name Florence James
15. Birthplace Tilghmans Md.

16 (a) Informant Richard S. Harrison
(b) Address 1637 Poplar Grove St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/18/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William Goldstrah M.D. Medical Examiner.
Date signed Oct 16, 1947

VS 181

Enter name of city, town, or county in which birth occurred. Fill in all items. Use ditto marks where necessary. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56094 2521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G56094

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~1138~~
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town DUNDALK (If outside city or town limits, write RURAL and give town)
(d) Street No. 1138 Dundalk Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ARAMINTA KAPELANCZYK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: HELVIN KOPELANCZYK.

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 4-10-07

8. AGE: Years 40 | Months 6 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation house wife

11. Industry or business Johns Hopkins Hospital

FATHER
12. Name Charles Dansinger
13. Birthplace Md

MOTHER
14. Maiden Name Emma Bothoff
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Oak Lawn
Location Eastern ave. Extended

18 (a) Funeral director Wm. Cook Inc.
(b) Address 127 St. Paul St.

OCT 17 1947 (Date rec'd by registrar) (b) Lexington Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1947 at 12:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1947 to 10-16 1947, and that I last saw her alive on 10-15 1947

	Duration
Immediate cause of death uremia	
Due to cerebral thrombosis	
Due to carcinoma of cervix uteri	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence A. Thaston Jr. M.D.
Address Johns Hopkins Hospital Date signed 10-16-47

G56095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42D

G56095 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 N. Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 N. Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary K. Gladding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or divorced. Widowed

6 (b) Name of husband ~~Samuel~~ Samuel L. B. Gladding

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22nd 1869

8. AGE: Years 78 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, state or foreign country)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name ? Garrison
13. Birthplace Md

MOTHER
14. Maiden Name Mary K. Garrison
15. Birthplace Md.

16 (a) Informant E. Chas. Gladding
(b) Address 1913 W. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/47 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) OCT 17 1947 (Date received by Registrar) (b) Huntington Hollins M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15th 1947, 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1947 to Oct 15 1947 and that I last saw h. alive on Oct 15 1947

Immediate cause of death	Duration
Cardiac Dilatation	1 day
Due to Chr. Valvular Heart	Hyps.
Due to Pneumonia Bronchial	1 Wk.
Other Conditions Other Illness	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E N Neuhardt M.D.
Address 1500 E. 33rd Date signed 10/17/47

G56096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 877

G56096 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 E. Bank Street
(c) Hospital or institution:
3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 E. Bank Stree t.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Sussan

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Married

6 (b) Name of husband or wife William J. Sussan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1883

8. AGE: Years	Months	Days	If less than one day
64	5	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Patrick Connelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary
15. Birthplace Ireland

16 (a) Informant William J. Sussan
(b) Address 1403 E. Bank Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/18/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) 10-17-1947 (Date received by Registrar) Washington Williams M.D. (Registrar)

VS 150 Page

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1947, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Sept. 1947, to 15 Oct. 1947, and that I last saw h alive on 11 Oct 1947

Immediate cause of death	Duration
Cerebral hemorrhage	5 hrs.
Due to Cerebral sclerosis	Many yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. E. Wiel M. D.
Address 920 St. Paul Date signed 16 Oct. '47

Balto. 2 X

G56097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56097 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Camp Holabird Hospital 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 S. Bouldin (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Franz C. Roese

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-4973

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Bertha Roese
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Aug 7 1879

8. AGE: Years	Months	Days	If less than one day
68	2	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Boiler Makers
11. Industry or business

FATHER
12. Name Ernst Roese
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Hoffmann
15. Birthplace Germany

16 (a) Informant Bertha Roese
(b) Address 306 S Bouldin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17 (month) (day) (year)
Cemetery or crematory Oak Lawn Cem
City
Director Ulrich Funeral Home
2008 Gla
(b) Registrar

OCT 17 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/47 19 , at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Ders M.D.
Medical Examiner.
Date signed 10/14/47

Important. Physicians: please write the causes of death clearly and legibly.

G56098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

135a

Registered No. G56098

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd St.
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #11 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3742 Hickory Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Rebecca Sherman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widowed

6 (b) Name of husband or wife Mr. James Sherman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 22 Aug. 1872

8. AGE: Years	Months	Days	If less than one day
75	1	22	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name? Benjamine Wetzel
13. Birthplace? Va

MOTHER
14. Maiden Name? Martha Bosley
15. Birthplace? Va

16 (a) Informant James Sherman
(b) Address 3742 Hickory ave

17 (a) Burial (b) Date thereof Oct 18.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Rural

18 (a) Funeral director Sulbert Funeral Home
(b) Address 2008 Orleans St

19 (a) OCT 17 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 October 1947, at 1020 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Sept 1947, to 14 Oct. 1947, and that I last saw her alive on 14 Oct. 1947.

Immediate cause of death Anoxia — Duration

Due to Pulmonary embolus

Due to

Other Conditions Lobar pneumonia, RLL, resolving
(Include pregnancy within 3 months of death)

Date of operation Cystoscopy

Major findings of operation: Cystitis, post. bladder.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles Richard Brown M. D.
Address Date signed

X

C56099 BCH #90010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

C56099 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 21

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanne Stadelmaier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 24 1867

8. AGE: Years	Months	Days	If less than one day
		21	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John G. Stadelmaier
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ruth Krauss
15. Birthplace Baltimore

16 (a) Informant Joanne Stadelmaier
(b) Address 2119 E Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18. (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Lillich Funeral Home
(b) Address 2008 Orleans St

19 (a) Oct 17 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1947, at 9:35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1947 to 10/15 1947, and that I last saw her alive on 10/15 1947

Immediate cause of death Respiratory Failure — Duration

Due to Post operation — Duration

Due to Gastro-Jejunostomy — Duration

Due to Duodenal Obstruction — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation 10/9/47

Major findings of operation: Duodenal Obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Benson M.D., M. D.

Address Hospital Date signed 10/15/47

656100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 813a

Registered 656100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3433 E. Lombard St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3433 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Augustus Reich

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-03-3707

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Lillie Reich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1873

8. AGE: Years	Months	Days	If less than one day
74	6	18	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name ?
13. Birthplace North Carolina

MOTHER
14. Maiden Name ?
15. Birthplace North Carolina

16 (a) Informant Archie Reich
(b) Address 605 N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/47 (month) (day) (year)
(c) Cemetery or crematory Glendale
Location Glendale, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 O leans St.

19 (a) OCT 17 1947 (Date rec'd by Registrar) Registrar

V S 158

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1947, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1947 to 10-14 1947 and that I last saw h[illegible] alive on 10-14 1947

Immediate cause of death Cerebral Hemorrhage — Duration 24 hrs
Due to Chronic arterio-sclerosis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. J. Davidow M. D.
Address 3218 Eastern ave Date signed 10-16-47

X

G56101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 No Gay St
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 No Gay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachael Esther Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/14/1877

8. AGE: Years 70 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Nusyn

13. Birthplace Russia

MOTHER 14. Maiden Name Ella

15. Birthplace Russia

16 (a) Informant Harry L. Bowen

(b) Address 1508 No Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run

Location

18 (a) Funeral director Jack Levin Inc

(b) Address 2402 Eutaw Place

19 (a) OCT 17 1947 (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16- 1947, at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1947 to 10/16 1947, and that I last saw her alive on 10/17 1947

Immediate cause of death: Acute Coronary Insufficiency — Duration

Due to: Coronary Sclerosis — Duration: Months

Due to: Myocardial Degeneration — Duration: Years

Other Conditions: Chronic Gall Bladder

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature L. H. Hornstein M. D.

Address 733 Argonath St Date signed 10/17/47

56102

LR 110309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Baker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-14-1680

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7- 1923

8. AGE: Years 24 | Months 3 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Barco
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Octo. 17-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn.

18 (a) Funeral director J. Brooks
(b) Address 4637 N. Carey St

19 (a) OCT 17 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13- 1947 at 7:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1947 to 10-13 1947 and that I last saw him alive on Oct. 13 1947

Immediate cause of death Pneumonia
Interval between onset and death 1 d
Due to Pulmonary Tuberculosis Bilateral
Due to Marasmus contributory
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Parker M. D.
Address Balt City Hosp Date signed 10-18-47

G56103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56103 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 S Rappolla St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name town)
(d) Street No. 503 S Rappolla St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Boniatski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Bonianski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Police Officer

11. Industry or business Police Dept

FATHER
12. Name Michael Boniatski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Poland

16 (a) Informant Mary Boniatski
(b) Address 503 S Rappolla St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 930 Eastern Ave

19 OCT 17 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1947, at 3 05 P M

21. I certify that I took charge of the remains described above, held an Inq & Insp thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kolodrubetz M.D. Medical Examiner.
Date signed Oct 15, 1947

VS 151

correct age is especially important. Physicians: please write

656104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. 656104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Streets
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3416 Dudley Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME William P Sullivan (William P. Sullivan)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	213-10-8973

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Jane C. Manning
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1891

8. AGE: Years	Months	Days	If less than one day
56 yrs	1	28	##### hr. ##### min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Patrick Sullivan
13. Birthplace Ireland

MOTHER
14. Maiden Name Virginia Burial
15. Birthplace Maryland

16 (a) Informant Doris Nebraska
(b) Address 3416 Dudley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave Balto Md

18 (a) Funeral director George J Ruth Inc
(b) Address 1734 Walbrook Ave

19 (a) OCT 17 1947 (Date received by registrar) (b) [illegible] Williamsport Md

VS 15d

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 19 47, at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 19 47 to Oct 16 19 47 and that I last saw h[illegible] alive on Oct 16 19 47

	Duration
Immediate cause of death: Peritonitis PERITONITIS	12 hrs
Due to Breakdown of duodenal stump	12 hrs
Due to Chronic Pyelitis Ulcer	years
Other Conditions Pyloric Obstruction	5 days

(Include pregnancy within 3 months of death)
Date of operation Oct 9, 1947
Major findings of operation: Gastric ulcer, Pyloric Obstruction
of autopsy: Disrupted duodenal stump

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Mercy Date signed 10-16-47

X

G56105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56105 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 James St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1301 James St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. King

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Delia T. Dolan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12th 1882

8. AGE: Years	Months	Days	If less than one day
65	4	4	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Byt Gar
11. Industry or business Self

FATHER
12. Name Michael King
13. Birthplace Ireland

MOTHER
14. Maiden Name Barbara Connelly
15. Birthplace Ireland

16 (a) Informant Mrs Delia T. King
(b) Address 1301 James St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Logan & Son
(b) Address 9403 Hollins St.

19 OCT 17 1947 (Date rec'd by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16th 1947, at 7.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1946 to Oct 16 1947 and that I last saw h[illegible] alive on Oct 15 1947

Immediate cause of death	Duration
Heart failure	1 week
Due to Hypertensive Cardio-Vascular Disease	60 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John P. Urlock, Jr.
Address 1227 Wash Blvd Date signed 10/18/47

File No. G56106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registration No. G56106

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15th Division St.
(c) Hospital or institution: Provident 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2352 McElderry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Calvin Butler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James H. Rochester
13. Birthplace Md.

MOTHER
14. Maiden Name Ibbie Heath
15. Birthplace Md.

16 (a) Informant Mrs. H. Calvin Butler
(b) Address 2231 Madison Ave.

17 (a) Burial (b) Date thereof Oct. 18, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee H. Holland
(b) Address 1631 Druid Hill Ave.

OCT 17 1947
(Date rec'd by Registrar) (b) Cutterton Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/ 1947 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1947 to 10/14 1947 and that I last saw h[illegible] alive on 10/14 1947.

Immediate cause of death
Uremia
Nephritis
Due to Hypertension C.V. Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
12 days
6 wks.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George T. McDonald M.D.
Address 844 N. Carey St. Date signed 10/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G56107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William V. Clark

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-0435

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Estella V. Clark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1883

8. AGE: Years 64 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace Stevensville Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Georgia Hamilton
15. Birthplace Unknown

16 (a) Informant William V. Clark
(b) Address 50 Briarwood Road

17 (a) Burial (b) Date thereof Oct. 18, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Mr. & Mrs. John W. Tuffendsen
(b) Address 5311 Edmondson Ave

19 (a) OCT 17 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1947 at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Res. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured skull
Intra cranial Hemorrhage.

Due to

Other Conditions Multiple fractures & contusions.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-14-47 at 6 P.M.
(b) Where did injury occur? 2214 N. Fulton Avenue
(Town)
(c) Did injury occur at home, on farm, industrial place, in public place? Tavern (Public) While at work? Yes
(d) Means of injury Fell from ladder while painting

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-15-47

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56108 94 8, 13

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution: University Memorial 94
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 Homewood Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Finley Ellsworth Butterbaugh

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-05-2041

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Butterbaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1885

8. AGE: Years	Months	Days	If less than one day
62	9	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Real Estate Investor.

11. Industry or business

FATHER
12. Name Joseph Butterbaugh
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Emily A. Ward.
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. F. Butterbaugh
(b) Address 2227 Homewood Ave, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1947, at 7:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1947, to Oct. 16 1947, and that I last saw him alive on Oct. 15 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John F. Hagen Jr. M. D.
Address Date signed

VS 150

X

G56109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G56109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5800 Berkley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5800 Berkley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HOFFMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	212-26-5632

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Meta E. Hoffman
nee Oehm 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1882

8. AGE: Years	Months	Days	If less than one day
65	0	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Insurance Agt.
11. Industry or business National Casualty

FATHER
12. Name Julius Hoffman
13. Birthplace Europe

MOTHER
14. Maiden Name Sophia Distelbart
15. Birthplace Unknown

16 (a) Informant Mrs. George Hoffman wife
(b) Address 5800 Berkley Ave.

17 (a) Burial (b) Date thereof 10.18.47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 17 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Oct. 15 1947, and that I last saw ... alive on Oct 15 1947.

Immediate cause of death	Duration
Coronary thrombosis	1 hr.
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard F. Glenn M. D.
Address 5611 Bentalou Ave. Date signed

G56110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G56110 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3900 Clifton Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Whitehurst

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Ruth O. Beans

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1888

8. AGE: Years 58 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Theatre Manager-retired

11. Industry or business

FATHER 12. Name William H. Whitehurst
13. Birthplace Phila., Pa.

MOTHER 14. Maiden Name Anna M. Redsecker
15. Birthplace Pa.

16 (a) Informant Mrs. Ruth O. Whitehurst
(b) Address 3900 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) OCT 17 1947 (Date rec'd by registrar) (b) Per writing for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16, 1947 19 , at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946, to 15 Oct 1947 and that I last saw him alive on 15 Oct 1947

Immediate cause of death: Bronco Pneumonia — Duration 4 days
Due to: Arteriosclerosis, Cardiac Decompensation — years
Due to: Renal Disease — years
Other Conditions: Paralysis Agitans — years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurinda L. Beans M.D.
Address 1938 Linden Ave. Date signed 10/17/47

VS 150

656111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 656111

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1934 Mt. Royal Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 Mt. Royal Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Page Kennedy

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Thomas W. Kennedy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1872

8. AGE: Years 75 | Months 7 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Arthur Page
13. Birthplace London

MOTHER
14. Maiden Name Mary Jane Campbell
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Eliza Engle
(b) Address 1710 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Road, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) OCT 17 1947 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1947, at 9:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15th 1947, to Oct. 15th 1947 and that I last saw h[illegible] alive on Oct. 11th 1947

	Duration
Immediate cause of death: Myocardial insufficiency	½ hour
Due to: Coronary arteriosclerosis	1 1/2 yrs.
Due to:	
Other Conditions: None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ferdinand F. Uhrstad M.D. M. D.
Address 1014 St. Paul St. Date signed 10-17-47

VS 150

G56112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 1312

Registered No. G56112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1052 N. Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1052 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam K. Bolden

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-2642

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1897

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Farmville Va. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co.

FATHER 12. Name Sam Bolden
13. Birthplace Va.

MOTHER 14. Maiden Name Addie Allen
15. Birthplace Va

16 (a) Informant Mary Bolden
(b) Address 1052 N. Gay St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 19 47 (month) (day) (year)

(c) Cemetery or crematory
Location Farmville Va

18 (a) Funeral director Mrs. Roff & Allied Dept
(b) Address 1129 N. Caroline St

OCT 17 1947 (Date rec'd by Registrar) (b) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1947 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1947 to Oct. 17 1947.
and that I last saw h[illegible] alive on Oct. 17 1947.

Immediate cause of death Tuberculen[illegible]tis — Duration 10 days

Due to Acute Miliary Tuberculosis — 1 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. LeRoy Berry M. D.
Address 1920 Chase Date signed Oct. 17 47

Wm. LeRoy Berry X

G56113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. G56113

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Rebecca Kates.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Louis M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2nd 1891

8. AGE: Years	Months	Days	If less than one day
56	4	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name John Briscoe
13. Birthplace Maryland.

MOTHER
14. Maiden Name Alice
15. Birthplace Maryland.

16 (a) Informant Louis M. Kates.
(b) Address 2208 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 17 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Road.

18 (a) Funeral director Edward Foulson
(b) Address 2359 Washington Blvd

19 (a) OCT 17 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1947, at 6 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6 1946 to 10-15 1947 and that I last saw her alive on 10-13 1947.

Immediate cause of death? Carcinoma, Larynx — Duration 1.5 yrs.

Due to

Due to

Other Conditions Metastasis Regional Lymph nodes
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John T. Schaefer

Address 212 St. Paul St. Date signed 10/18/47

G56114 B-C-S-12147 BALTIMORE CITY HEALTH DEPARTMENT G56114

CERTIFICATE OF DEATH 1570 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address? ✓
(c) Hospital or institution: West Baltimore General Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 min.

2. USUAL RESIDENCE OF DECEASED: ✓
(a) State Md. (b) County
(c) City or town Balto. 30, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Wilcomico St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Elaine Bogardus

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 15 47

8. AGE: Years	Months	Days	If less than one day
			hr. 30 min.

9. Birthplace West Balto. Gen. Hosp. Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. and Raymond Bogardus
13. Birthplace Union City, Pa.

MOTHER
14. Maiden Name Laura Ellen Easton
15. Birthplace Cherry Grove, Md.

16 (a) Informant Laura Easton Bogardus
(b) Address 1123 Wilcomico St.

17 (a) Buried (b) Date thereof 10/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ivy Hill
Location Princess George County

18 (a) Funeral director Oldfield Selby
(b) Address 420 E. Lafayette Ave. Baltimore Md.

19 OCT 17 1947 Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15 1947 at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1947 to 10-15 1947 and that I last saw her alive on 10-15 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Hydrocephalus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Treptow M. D.
Address W. Balto. Gen. Hosp. Date signed 10-17-47

G56115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. G56115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City Morgue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3830 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALFRED L. SCOTT

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-1874

8. AGE: Years	Months	Days	If less than one day
73.	1	8	hr. min.

9. Birthplace Bloomsbury N. J.
(Town, county, and state)
10. Usual Occupation General mechanic
11. Industry or business Self

FATHER
12. Name Hugh B. Scott
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Jane Smythe
15. Birthplace N. Y.

16 (a) Informant Mrs. Mary S. Scott
(b) Address 3830 Reisterstown Rd

17 (a) Burial (b) Date thereof 10-20-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Stewartstown
Location Stewartstown, Pa

18 (a) Funeral director Duggan Funeral Home
(b) Address 3621 Ffells Road

19 (a) OCT 17 1947 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1947 at 4:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to Fatty degeneration of liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George B. Merrill M.D.
Medical Examiner
Date signed 10/17/47

G56116 CERTIFICATE CORRECTED 4-14-50 ✓ G56116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 315 E. Street
(c) Hospital or institution: Franklin Sq. Hospital 512
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) XIV

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1
City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 East Street. (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country Italy

3 (a) FULL NAME [redacted] PETROLI

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Rosalie
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 11-22-75

8. AGE: Years	Months	Days	If less than one day
71	11	10	24 hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name [redacted] Unknown
13. Birthplace Italy.

MOTHER
14. Maiden Name Maria Salvatore
15. Birthplace Italy.

16 (a) Informant Wife
(b) Address 315 E. Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Morley St.

19 (a) OCT 17 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16, 1947, at 6 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1947, to Oct 16, 1947, and that I last saw him alive on Oct 16, 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] M.D.
Address Franklin Sq. Hosp. Date signed 10/18/47

X

C56117 FL. 114427 CC# 689182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C56117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Trappe Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1947

8. AGE: Years	Months	Days	If less than one day
	1	8	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wilson Morris
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Patterson
15. Birthplace W. Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory H. Matthews
Location O'Donnell St
Lilly & Zeile
18 (a) Funeral director
(b) Address 403 N. Bolton St.

19 (a) OCT 17 1947 Washington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 19 47, at 3.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 19 47 to Oct. 16 19 47, and that I last saw h[illegible] alive on Oct. 16 19 47

Immediate cause of death	Duration
[illegible] Bronchopneumonia	
Due to Pertussis	7 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: about

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold H. Beeton, M.D.
Address Balto City Hosp. Date signed 10/17/47

056118 B.C.# A-92678

LW 114558

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered 056118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 N. Linwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS MAIVELETT

3 (b) If veteran, name war: none.
3 (c) Social Security Account No. none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16-1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Louis Maidelett
13. Birthplace Italy

MOTHER 14. Maiden Name Frances ANNELLO
15. Birthplace Md. Balto.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director C. E. SCHIMUNEK
(b) Address 2611-35 E. MADISON. ST

19 OCT 17 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1947, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1947 to Oct. 17 1947, and that I last saw him alive on Oct. 17 1947

Immediate cause of death: Premature Duration 15 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reginald H. Beeler M. D.
Address Date signed 10/17/47

G56119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G56119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto Md
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Kelly Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS FLORENCE SHAFFER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Peter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30-1877

8. AGE: Years 70 | Months 6 | Days 15 | If less than one day ___ hr. ___ min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation house work

11. Industry or business

FATHER
12. Name Noah Martin
13. Birthplace Md

MOTHER
14. Maiden Name Kessler
15. Birthplace unknown

16 (a) Informant Calvin Shaffer
(b) Address 1505 Lemon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-47 (month) (day) (year)
(c) Cemetery or crematory St Marys (Hampden)
Location Baltimore

18 (a) Funeral director Frank H Getz
(b) Address 814 N 36 St

19 (a) OCT 17 1947 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15, 1947, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1, 1947, to Oct 15, 1947, and that I last saw her alive on Oct 15 1947.

Immediate cause of death Carcinoma of Stomach with Metastases — Duration

Due to —

Due to —

Other Conditions Possible old Pulmonary tuberculosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan Y. Wolinsky M.D.
Address Sinai Hospital Date signed Oct 15, 1947

VS 150

G56120 HEALTH DEPARTMENT—CITY OF BALTIMORE G56120

CERTIFICATE OF DEATH

95c

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4700 WALTHER St. ✓ Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME MARY SACK ✓

If U.S. Veteran specify WAR ...

(a) Residence: No. 4700 WALTHER St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	W.	MARRIED

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of LT. ERNEST SACK

6. DATE OF BIRTH (month, day, year) JUNE 21 1870

7. AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	77	3	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. HW.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) BALTIMORE, MD

FATHER

13. NAME WILLIAM WALCH

14. BIRTHPLACE (city or town) (State or country) GERMANY

MOTHER

15. MAIDEN NAME UNKNOWN

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT HUSBAND.
(Address) 4700 WALTHER BLVD.

18. BURIAL, CREMATION, OR REMOVAL
Place Parkwood Date Oct 20 19 47

19. UNDERTAKER Lanahan Lemmon & Hart
(Address) 2401 Eutaw Ave.

20. FILED OCT 17 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) OCT. 16, 1947

22. I HEREBY CERTIFY, That I attended deceased from JULY, 1947 to OCT 16, 1947

I last saw h ER alive on 10/16 1947 Death is said to have occurred on the date stated above, at 4:30 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
HYPERTENSION (MIND.)	
CARDIAC DILATION WITH DECOMPENSATION	1947
CARDIAC DECOMPENSATION	
GENERALIZED EDEMA	1947

Other contributory causes of importance

Was an operation performed? No Date of

For what disease or injury?

What test confirmed diagnosis? CLINICAL Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Walter E. Kaylor M. D.

(Address) 4331 Harford Rd

X

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C56121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. C56121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1231 N. Broadway
(c) Hospital or institution: St Josephs
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Unis

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: George
6 (c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): Aug. 26, 1903
8. AGE: Years: 44 Months: 1 Days: 21 If less than one day: hr. min.
9. Birthplace: Harwood Penn. (Town, county, and state)
10. Usual Occupation: at home
11. Industry or business

FATHER
12. Name: Frank O'Donnell
13. Birthplace: Harford Penn.

MOTHER
14. Maiden Name: Mary McCauley
15. Birthplace: Penn.

16 (a) Informant: George Unis
(b) Address: 1234 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd.

18 (a) Funeral director: Mar. E. Bryan & Sons
(b) Address: Cor. Hoyd & Ann Sts

19 OCT 17 1947 (Date rec'd by registrar) Huntingtown, Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1947, at 9 10/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1947 to Oct 16 1947, and that I last saw her alive on Oct 2 1947.

	Duration
Immediate cause of death: Pulmonary hemorrhage	1 hr
Due to: Carcinoma of lung (metastatic)	?
Due to: Carcinoma of cervix (Squamous cell)	18 mos
Other Conditions: Generalized metastasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Helen L. Longenecker M. D.
Address 1444 S. Ann St Date signed 10/17/47

C56122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. C56122

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 S. Ann St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Basto (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 S. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna H. Zaworska

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-4832

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife ~~None~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1885

8. AGE: Years 61 | Months 11 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Basto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Zaworska
13. Birthplace Prussia

MOTHER 14. Maiden Name Frances Dabrochowska
15. Birthplace Prussia

16 (a) Informant Mary Lackman
(b) Address 220 S. Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Covenant Hill Rd.

18 (a) Funeral director M. W. E. Dyer & Son
(b) Address 2040 Eastern Ave.

19 (a) OCT 17 1947 (Date received by registrar) (b) Huntington Hospital, Md. (Registrar)

V S 150

MEDICAL CERTIFICATION

DATE OF DEATH Oct 16 1947 at 4:P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Oct 16 1947, and that I last saw her alive on Oct 16 1947

Immediate cause of death Carcinoma of Stomach — Duration Nov 1946

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Myron L. Solomon
Address 179 S. Broadway Date signed 10/20/47

G56123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G56123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 144 W. Hill St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 144 W. Hill St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN GARDNER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. - SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1892

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation

11. Industry or business LABOR.

FATHER 12. Name UNKNOWN
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant MISS BESSIE ARNOLD
(b) Address 144 W. HILL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10 18 47 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location WOODLAWN, MD.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST - 30

19 OCT 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 15 1947, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 18, 1947 to OCT. 15 1947 and that I last saw him alive on OCT. 13 1947.

Immediate cause of death Carcinoma of the Stomach with metastases in the liver — Duration 2 YRS
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James E Peterman M. D.
Address 1226 Hanover St Date signed 10/17/47

X

656124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 656124

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1470 N Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1470 N Carey St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Ezra Murdock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Parthenia Murdock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1876

8. AGE: Years	Months	Days	If less than one day
71	7	9	hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Edward Murdock
13. Birthplace Md.

MOTHER
14. Maiden Name Cecelia —
15. Birthplace Md

16 (a) Informant Parthenia Murdock
(b) Address 1470 Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/'47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cemetery
Location Arbutus Md

18 (a) Funeral director Chas H Alexander
(b) Address 1200 McCulloh St.

19 (a) 10-17-1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1947, at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1947 to Oct 16 1947 and that I last saw him alive on Oct 16 1947.

Immediate cause of death Chronic Valvular Heart Disease — Duration Unknown
Due to Cerebral Hemorrhage. — 2 days
Due to Hypertension — Unknown
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.

23. Signature William Frey
Address 928 Penna Ave Date signed 10/17/47

VS 150

C56125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C56125

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 1319 Hendrson ave
(a) Baltimore City, Maryland
(b) Street address 236 Amity St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 Amity St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura V. Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John H. Johnson.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1881

8. AGE: Years 66 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Morris Chambers.

13. Birthplace Md.

MOTHER

14. Maiden Name Rachel Murdock,

15. Birthplace Md.

16 (a) Informant David L. Johnson.

(b) Address 1319 Cullob Project.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18, 1947 (month) (day) (year)

(c) Cemetery or crematory Asbury

Location Town Neck, A. A. Co. Md

18 (a) Funeral director Mrs. Katie R. Wallin

(b) Address 322 N. Schroeder St. Huntington Station, Md.

19 (a) (b) Registrar

OCT 17 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1947 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1947 to Oct 14 1947 and that I last saw h e alive on Oct 14 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 1 hr

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M. D.

Address 315 E. Baltimore Date signed 10/16/47

X

G56126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Howard Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County CARROLL
(c) City or town WESTMINSTER (If outside city or town limits, write RURAL and give town)
(d) Street No. 158 LIBERTY ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME DAVID E. FRANKLIN

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No. 218-09-5293

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: DAISY F.
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) APR 10, 1907

8. AGE: Years	Months	Days	If less than one day
40	6	10	..... hr. ..... min.

9. Birthplace: Carroll Co. Md. (Town, county, and state)
10. Usual Occupation: Garage Work
11. Industry or business

FATHER — 12. Name: Daniel E. Franklin
FATHER — 13. Birthplace: Md
MOTHER — 14. Maiden Name: Ella Grack
MOTHER — 15. Birthplace: Md.

16 (a) Informant: Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-47 (month) (day) (year)
(c) Cemetery or crematory: Winters Cemetery
Location: Near New Windsor, Md.

18 (a) Funeral director: J. Francis Reed
(b) Address: Westminster Md.

19 (Date received by Registrar) OCT 17 1947 Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17 1947, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1947 to Oct 17 1947, and that I last saw h.IM. alive on Oct 17 1947

Immediate cause of death: Respiratory Failure — Duration
Uric. Failure
Due to: Generalized Capillary hemorrhage.
Due to: Cancer 3-4 degree uterus
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: NONE

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: accident
(b) Date of occurrence: 10-15-47 at A.M.
(c) Where did injury occur? Garage: Westminster (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Industrial (Specify type of place) While at work? Yes
(e) Means of injury: Burned by blast torch.
23. Signature: H.R. Manchester Jr. M. D.
Address: Univ. Hosp. Balt. Date signed 10/17

Howard J. Williams, M.D.

G56127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56127

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 Argyle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jervase R. Gough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4 1881

8. AGE: Years 66 | Months 8 | Days 11 | If less than one day hr. min.

9. Birthplace St. Marys Co. Md.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Ambrose Gough
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Lucy Butler
15. Birthplace St. Marys Co. Md.

16 (a) Informant Mrs. Emma Sullivan
(b) Address 1418 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18, 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto, Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) OCT 18 1947 (Date received by Registrar) (b) Number for Baltimore, Md. 0 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1947 4½ P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1947 to Oct. 15 1947, and that I last saw him alive on Oct. 15 1947.

Immediate cause of death Bronchopneumonia

Due to Terminal

Due to

Other Conditions Chr. Myocarditis. Hypertension.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Covill Jr.
Address 1418 Argyle Ave. Date signed Oct. 18 1947

X

G56128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered G56128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd.
(c) Hospital or institution:
Haven Nursing Home. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 10
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3946 Oakford Ave #15
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida De Neale Risheill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Thomas L. Risheill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1872

8. AGE: Years	Months	Days	If less than one day
74	11	14	hr. min.

9. Birthplace Alexandria, Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Lyle
13. Birthplace Alexandria, Va.

MOTHER
14. Maiden Name Janet DeNeal
15. Birthplace Alexandria, Va.

16 (a) Informant Jeanette R. English
(b) Address 1111 S. Washington St. Alexandria, Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-17-47 (month) (day) (year)
(c) Cemetery or crematory
Location Alexandria, Va.

18 (a) Funeral director Wm J. Tickner & Sons,
(b) Address North & Penna. Aves. Balto, Md.

19 OCT 18 1947 (Date rec'd by registrar) (By) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1947, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1947, to Oct 17 1947, and that I last saw her alive on Oct 17 1947.

Immediate cause of death	Duration
Arteriosclerotic C-V-D & Myocarditis	7
Due to Generalized Arteriosclerosis	3
Due to	
Other Conditions Cerebral Arteriosclerosis	2

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John M. Scott M. D.
Address 8 Longwood Rd. Date signed Oct 17, 47

556129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 556129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2724- Maryland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARL F. HENNIES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of ~~husband or~~ wife Lela A. Hennies

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29th 1869

8. AGE: Years 77 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Confectioner

FATHER 12. Name (Unknown) Hennies

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Albert R. Hennies (Son)

(b) Address Brentwood Md.

17 (a) Burial (b) Date thereof 10/20/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balts

Location " Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul st.

19 OCT 18 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16, 1947, at 8.25 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, Intra cranial hemorrhage

Due to

Other Conditions Multiple fractures, abrasions, and bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12/6

(a) Date of injury 10-16-47, 6. P. M. Charles near 29th St.

(b) Where did injury occur? Baltimore, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pediastrian-struck by auto

23. Signature Howard J. Mueller M.D.
Medical Examiner.

Date signed 10-17-47

G56130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G56130 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 Tyrrell Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1731 Tyrrell Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Westerfield

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11 1881

8. AGE: Years	Months	Days	If less than one day
66	6	5	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Manufacturer Man
11. Industry or business Tobacco Dept

FATHER 12. Name Westerfield
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Emma L Westerfield
(b) Address 1731 Tyrrell Place

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilhelm & Son
(b) Address 1211 E Fayette St

19 OCT 18 1947 (Date filed by registrar) Courtesy for Williams MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1947, at 6 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Oct 16 1947 and that I last saw him alive on Oct 16, 1947.

Immediate cause of death	Duration
Coronary Thrombosis	4 days
Due to Arterio Sclerotic Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward Wolfe M.D.
Address 1331 E Monument St Date signed 10-17-47

VS 150

G56131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G56131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington Street
(c) Hospital or institution:
Home of our Lady
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Barclay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Festerman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widowed

6 (b) Name of husband or wife John Festerman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1882

8. AGE: Years	Months	Days	If less than one day
64	11	26	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Flynn
13. Birthplace Ireland

MOTHER
14. Maiden Name Winefred McEle
15. Birthplace Ireland

16 (a) Informant Catherine Mulligen
(b) Address 1044 Brentwood Avenue

17 (a) burial (b) Date thereof 10/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 18 1947 (b) Thomas Joseph Mulligan M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1947 to Oct 16 1947, and that I last saw h[illegible] alive on Oct 15 1947

Immediate cause of death: Uremia & Acute Bronchopneumonia

3 Duration Days

Due to

Due to

Other Conditions Advanced Arteriosclerosis Marked Venesection

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Statton Supervisor M. D.
Address 1348 Bond St. Date signed Oct 16 1947

056132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered 056132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 St. Paul Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMIL A. NELSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 092-07-9954

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Aino Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29th 1889

8. AGE: Years	Months	Days	If less than one day
58	1	17	hr. min.

9. Birthplace Finland
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Brooklyn Navy Yard

FATHER
12. Name Niku Isaaca
13. Birthplace Finland

MOTHER
14. Maiden Name (Unknown)
15. Birthplace "

16 (a) Informant Kauko Nenonen
(b) Address 412 St. Paul St.

17 (a) Cremation (b) Date thereof 10/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 18 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16, 1947, at 11.30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial hypertrophy and degeneration
Coronary Artery Disease
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Morrell M.D.
Medical Examiner.
Date signed 10-17-47

VS 181

G56133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

Registered No. G56133

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully filled in. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST. JOSEPH'S HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 10 d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 WILCOX ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME KATHERINE McQUILLAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1875

8. AGE: Years	Months	Days	If less than one day
72	1	1	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name John McQuillan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary O'Brien
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Hilliard
(b) Address 935 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20/47 (month) (day) (year)
(c) Cemetery or crematory Mayr Cathedral Cem. Location 4300 Old Frederick Rd.

18 (a) Funeral director Edmund W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) OCT 18 1947 (Date received by registrar) (b) Hamilton-Northern-Hilleary Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1947 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 1947 to 10/17 1947 and that I last saw h-e alive on 10/17 1947

Immediate cause of death RESPIRATORY FAILURE — Duration
Due to PNEUMONIA, BOTH LOWER LOBES
Due to TERMINAL, FRACTURE, R. HIP
Other Conditions NAILED FRACTURE, R. HIP, HYPERTENSIVE ART. SCL. C.V.D.
(Include pregnancy within 3 months of death)
Date of operation 7/14/47
Major findings of operation: FRACT. INTERTROCHANTERIC, R. FEMUR
of autopsy: PNEUMONIA, EPC LIVER

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 7/6/47 at 3 PM
(c) Where did injury occur? BALTO MD (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? NO
(e) Means of injury FALL - Wood floor fell
23. Signature Henry P. Potts M.D.
Address St. Joseph's Hosp Date signed 10/17/47

VS 130 TO BE SIGNED BY MEDICAL EXAMINER Howard J. Madden, M.D.

G56134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G56134

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct as far as possible. Information is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Mohawk Avenue
(c) Hospital or institution: "Anderson Home"
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Months 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 Penhurst Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Annie Fawcett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17 - 1861

8. AGE: Years	Months	Days	If less than one day
84	10	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Dr. Christopher Fawcett
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Stephenson Fawcett
15. Birthplace Ireland

16 (a) Informant Mrs. Helen Knipp (Niece)
(b) Address Williamsburg, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Stewart & Mowen Co.
(b) Address Baltimore, Md.

19 (a) OCT 18 1947 (Signature for Williamsburg Registrar)
(Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15 1947 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 19 and that I last saw [illegible] alive on 10/15 1947

Immediate cause of death	Duration
Due to Carcinoma of the Rectum	10 yrs 4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Fawcett M.D.
Address 3902 Groveland Ave. Date signed 10/17/47

G56135 Second Informant Card

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Marys
(c) City or town RIDGE
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MATTHEW TRIMBLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lucy
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 187?

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

(a) [illegible] (b) Date thereof 10 | 22 | 47
(month) (day) (year)
Cemetery or crematory Rock Creek
Location Washington, D. C.

18 (a) Funeral director W. E. Callingham Sons
(b) Address Temperance, Md.

19 (a) OCT 18 1947 Washington Williams M.D.
(Date rec'd by registrar) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947, at 3:10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1947 to Oct 18 1947, and that I last saw h[illegible] alive on Oct 18 1947.

Immediate cause of death	Duration
Not definitely known - ? Myocardial infarction	
Due to Cerebrovascular, generalized Hypertensive Cardiovascular Disease	
Due to Anemia, probably post-hemorrhagic ? myelophthisic	
Other Conditions ? Malignancy	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman E. Shaffer M. D.
Address Johns Hopkins Hospital Date signed 10-18-47

G56136 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G56136

CERTIFICATE OF DEATH 93c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2535 Ashton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2535 Ashton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH - V. HANNA.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married.
6 (b) Name of husband or wife: JOSEPH-W. HANNA
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 8-1884.
8. AGE: Years 63 | Months 0 | Days 8 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county and State)
10. Usual Occupation House Wife.
11. Industry or business

FATHER
12. Name Wm. H. King.
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary Birchmuller.
15. Birthplace Md.

16 (a) Informant Mrs. Joseph W. Hanna
(b) Address 2535 Ashton St.

17 (a) Burial. (b) Date thereof Oct. 20-47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

19 (d) OCT 18 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October, 16. 1947, at 1 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Oct 16 1947. and that I last saw him alive on Oct 16 1947
Immediate cause of death Pulmonary Oedema — Duration
Due to Hypertension
Due to Rheumatic fever.
Other Conditions Asthenia Deformans
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert C. Hatch M.D.
Address 2151 Maryland Ave Date signed Oct 17/47

V S 150

C56137 Alessi

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Register No. C56137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5928 Glen Oak Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5928 Glen Oak Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Henry Kahler, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-12-3079

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Barbara Kahler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1889

8. AGE: Years	Months	Days	If less than one day
58	0	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Policeman
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Barbara Kahler
(b) Address 5928 Glen Oak Avenue, 14

17 (a) Burial (b) Date thereof 10-20-47
(Burial, cremation, removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5505 Harford Road, 14

19 (a) OCT 18 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16th, 1947, at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1937 to Oct 16 1947, and that I last saw h. alive on Oct 16 1947.

Immediate cause of death	Duration
Coronary Thrombosis	2 hrs.
Chronic myocarditis	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 6217 Harford Rd Date signed 10/19/47

X

C56138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C56138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2619 Woodbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2619 Woodbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SADIE K. KLEEMAN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: Raymond T. Kleeman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1899

8. AGE: Years	Months	Days	If less than one day
47	10	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John F. Kelly, Sr.
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Gill
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Raymond T. Kleeman
(b) Address 2619 Woodbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1947 at 1:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to Oct 16 1947 and that I last saw him alive on Oct 16 1947.

Immediate cause of death	Duration
(a) Hypertensive Cardio-Vascular Disease	
Due to (b) Cerebral Hemorrhage	
Due to (c)	
Due to (d)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis T. Levy
Address 1644 W. North Ave. Date signed 10/18/47

X

G56139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G56139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Madison St.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co.
(c) City or town Severna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph MacMurray, Sr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma A. MacMurray nee Hoos
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): April 16, 1887
8. AGE: Years 60 | Months 6 | Days 1 | If less than one day hr. min.
9. Birthplace: Bowling Green, Ohio (Town, county, and state)
10. Usual Occupation: Contractor
11. Industry or business: Self

FATHER
12. Name: Clois MacMurray
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Lenora Munn
15. Birthplace: Ohio

16 (a) Informant: Mr. Donald MacMurray
(b) Address: Severna Park, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 18 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1947, 1:02 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1947, to 10-17 1947, and that I last saw him alive on October 16 47

Immediate cause of death: Acute Coronary Thrombosis with cardiac failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Gordon Monroe Jr. M. D.
Address Md. Gen. Hosp. Date signed 10-17-47

VS 150

G56140 — BALTIMORE CITY HEALTH DEPARTMENT — G56140

CERTIFICATE OF DEATH 97

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George August Voertman

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Frances H. Voertman nee Hettinger 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1867

8. AGE: Years	Months	Days	If less than one day
80	1	16	hr. min.

9. Birthplace Portage, Wisconsin
(Town, county, and state)
10. Usual Occupation Race Tracks
11. Industry or business

FATHER
12. Name August Voertman
13. Birthplace Germany

MOTHER
14. Maiden Name Emilie Arsand
15. Birthplace Lorraine, France

16 (a) Informant Miss Eloise Voertman, Daughter
(b) Address 406 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) OCT 18 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1947, at 5:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1947, to Oct 17 1947, and that I last saw h— alive on Oct 17 1947

Immediate cause of death	Duration
Shock	
Due to Fract. femur	
Due to	
Other Conditions Hemiplegia, Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation Amputation of left leg 10-15-47
Major findings of operation:
Gangrene - left leg
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William F. Love M. D.
Address Bon Secours Hosp. Date signed 10-17-47

X

056141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 056141

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Eadman Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THE REVEREND JOHN SLADE GERMAN, D. D.

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
—	NO	M	W	Married

6 (b) Name of husband or wife Mrs. Cora M. German
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Minister (Methodist)
11. Industry or business Minister (Methodist)

FATHER
12. Name William M. German
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Sarah P. Slade
15. Birthplace Balto, Md.

16 (a) Informant Mrs Cora M. German
(b) Address 2408 Eadman ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director W.M. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1947, at 1100 am

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1947, to Oct 17 1947, and that I last saw h.i.m alive on Oct 17 1947

	Duration
Immediate cause of death Pulmonary edema	6 hrs
Due to Cardiac insufficiency due to sclerosis	2 yrs
Due to Arteriosclerotic heart disease	10 yrs
Other Conditions Hypertension - Cerebrovascular disease	10 yrs

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Bachanach M. D.
Address Church Home + Hosp Date signed 10/18/47

X

G56142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 LIGHT ST.
(c) Hospital or institution: SOUTH BALTO. GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO. (CO.)
(c) City or town 210 E. BARNEY ST.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 E. BARNEY ST. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUST CHRISTIAN ROBERG

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (c) If alive, give age
Male	White	Widower	yrs.

6 (b) Name of husband or wife BERTHA

7. Birth date of deceased (mo., day, yr.) Oct 6, 1863

8. AGE: Years	Months	Days	If less than one day
84		10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired Carpenter
11. Industry or business

FATHER — 12. Name	Robey
FATHER — 13. Birthplace	Germany
MOTHER — 14. Maiden Name	Gottschere
MOTHER — 15. Birthplace	Germany
16 (a) Informant	Ernest F. Robey
(b) Address	514 E. Fort Ave
17 (a) (Burial, cremation, or removal)	Burial (b) Date thereof (month) (day) (year) Oct 18 1947
(c) Cemetery or crematory	Mt. Carmel
Location	Balto. Md.
18 (a) Funeral director	A. Raymond Zellers
(b) Address	1410 E. Chase St.
19 (Date filed by registrar)	OCT 18 1947 Signature for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1947 at 3:02 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1947, to 10/16 1947, and that I last saw h/M alive on 10/16 1947.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	
Due to CEREBRO VASCULAR ACCIDENT.	
Due to HYPERTENSIVE ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William B. Cooper Jr. M.D.
Address SOUTH BALTO. GEN. HOSP. Date signed 10/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G56143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 338

Registered No. G56143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 S Charles
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 1508 S Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Manetta V. Morley

3 (b) If veteran, name war None
3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Alonzo F. Morley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1881

8. AGE: Years 66 | Months | Days 25 | If less than one day ___ hr. ___ min.

9. Birthplace Burkittsville, Frederick Co Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Wolfe
13. Birthplace Md

MOTHER
14. Maiden Name Sallie Mediary
15. Birthplace Md

16 (a) Informant Sylvia L. Corkery
(b) Address 1508 S Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director A. Bullard Evans
(b) Address 1400 S Charles St

19 OCT 18 1947 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1947, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 17 1947 and that I last saw h[illegible] alive on Oct 17 1947.

Immediate cause of death	Duration
Acute Endocarditis	1 week
Due to Influenza	2 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. B. Wolfe M.D.
Address 1279 Williams St Date signed 10/21/47

V S 150

G56144

BALTIMORE CITY HEALTH DEPARTMENT G56144 Registered No.

CERTIFICATE OF DEATH 157 M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Cuyahoga Falls (If outside city or town limits, write RURAL and give town)
(d) Street No. 1946 Chramet Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alma E. Bosson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-28-47

8. AGE: Years | Months: 6 | Days: 21 | If less than one day: hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Bosson
13. Birthplace Ohio

MOTHER 14. Maiden Name Sandella Perecco
15. Birthplace Ohio

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Mount Peace (Burial, cremation, or removal) (b) Date thereof Oct 21 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Peace
Location Akron, Ohio.

18 (a) Funeral director Palmer Mitchell & Sons
(b) Address 1800 Eutaw Place.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947, at 11 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1947 to Oct 18 1947, and that I last saw h[illegible] alive on Oct 18 1947.

Immediate cause of death: Air Embolism — Duration: 10 min.
Due to: Following Air Encephalogram.
Due to:
Other Conditions: Achondroplasia

(Include pregnancy within 3 months of death)
Date of operation 10-18-47
Major findings of operation: [illegible]
of autopsy: Air Embolism

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur B. Lang
Address Johns Hopkins Date signed 10/18/47 M. D.

VS 150

G56145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G56145 Registered No.

1. PLACE OF DEATH: West Baltimore General Hosp
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 N Appleton St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Davidson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant: Jacob Davidson
(b) Address 1637 N Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Signature of person(s) [illegible] (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Oct 1947, at 2250 M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Oct 1947 to 17 Oct 1947 and that I last saw h[illegible] alive on 17 Oct 1947.

Immediate cause of death: Bronchopneumonia — Interval
Anoxemia
Due to: Chronic Emphysema
Due to:
Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Chatcher
Address W.B. General Hosp Date signed 7 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G56146 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2235 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2335 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 77 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Retired

FATHER
12. Name: Hyman Goldberg
13. Birthplace: Poland

MOTHER
14. Maiden Name: Esther Muscatbit
15. Birthplace: Poland

16 (a) Informant: Samuel Goldberg
(b) Address: 2335 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19, 1947 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Hebrew Cem
Location: Belair Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) ... (b) ...
(Date rec'd by registrar) Registrar

OCT 19 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1947, at 1.P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1947 to 10-17 1947 and that I last saw him alive on 10-17 1947.

Immediate cause of death: Coronary thrombosis — Duration: 6 days

Due to: Coronary artery disease

Due to: generalized arteriosclerosis

Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature: Irving Freeman M. D.
Address: 2401 Eutaw Pl Date signed: 10-17-47

G56147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G56147 Registered No.

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John St.
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2640 Ashley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva, Hinda, Shmuckler

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband ~~or wife~~ David Shmuckler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace ?, Russia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Sander Weinblatt
13. Birthplace Russia

MOTHER
14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant Benjamin Shmuckler
(b) Address 2640 Ashley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-47 (month, day, year)
(c) Cemetery or crematory Sherree Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) OCT 19 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1947, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1947 to Oct. 18 1947, and that I last saw her alive on Oct. 18 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Myocardial infarction	
Due to Coronary arteriosclerosis	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank H. Logan M. D.
Address Hosp. for Women of Md. Date signed 10-18-47

94a

G56148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

G56148 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts.

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days) 38 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 3602 Greenlay Rd City 15 (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Joseph Libauer (Hode)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph Libauer

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) April 15, 1876

8. AGE: Years 71 | Months 6 | Days 3 | If less than one day ___ hr. ___ min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name ? Sundel

13. Birthplace Lithuania

MOTHER

14. Maiden Name Hannah Graff Getz

15. Birthplace Lithuania

16 (a) Informant Joseph Libauer

(b) Address 3402 Greenlay Rd. City 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-47 (month) (day) (year)

(c) Cemetery or crematory Beth Tefiloh

Location Woodson Mill Road

18 (a) Funeral director Jack Lewis Inc

(b) Address 2106 Eutaw Place

19 (a) 1947 (Date rec'd by registrar) (b) ___ Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1947, at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Oct. 18 1947, and that I last saw her alive on Oct. 18 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Peritonitis	16 hrs.
Due to Unknown Cause	
Other Conditions Anemia, sec to Hypernephroma, generalized	5 mos.

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. R. Smith, Jr. M.D.

Address Union Memorial Hosp. Date signed Oct. 19 47

LW 1656149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G56149
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 German Hill Rd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Joyce Jean Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7—1947

8. AGE: Years | Months | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Gilbert Gordon
13. Birthplace Va.

MOTHER
14. Maiden Name Phyllis Lucas
15. Birthplace Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Matthias
Location O'Donnell St.

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Linwood St.

19 (a) ____ (b) ____
(Date received by registrar) Registrar

OCT 19 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1947, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1947 to Oct. 16 1947, and that I last saw her alive on Oct. 16 1947.

	Duration
Immediate cause of death Pneumonia	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold H. Becker, M.D.
Address Balto City Hospitals Date signed 10/17/47

G56150 BALTIMORE CITY HEALTH DEPARTMENT G56150
BC# G91682 CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 EASTERN AVE. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME BABY (MYER) #2. MYERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 - 14 - 1947

8. AGE: Years 0 | Months 0 | Days 1 | If less than one day 2 hr. 50 min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name URBAN MEYERS
13. Birthplace MD.

MOTHER
14. Maiden Name JANE MARIE SELDOMRIDGE
15. Birthplace MD.

16 (a) Informant URBAN MEYERS
(b) Address 2505 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-18-47 (month) (day) (year)
(c) Cemetery or crematory OAK HILL
Location HORNERS LANE

18 (a) Funeral director LILLY & ZEILER INC
(b) Address 403 S. WOLFE ST.
Filed 10/19/47 Towson Washington Co. Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15/1947, at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15/1947 to 10/15/1947 and that I last saw him alive on 10/15/1947.

Immediate cause of death	Duration
Congenital failure	
Due to Premature birth	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin Cohen
Address Sinai Hosp Date signed (M. D.) 10/15/47

VS 150

X

G56151 BALTIMORE CITY HEALTH DEPARTMENT

BCH 691681 CERTIFICATE OF DEATH 159 Reg G56151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The next of kin is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME Baby Myer - # (Myers)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-14-1947

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 7 hr. 20 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation -
11. Industry or business -

FATHER 12. Name Urban Meyers
13. Birthplace Md.

MOTHER 14. Maiden Name June Marie Seldomridge
15. Birthplace Md

16 (a) Informant Urban Meyers
(b) Address Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-47 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horners Lane

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15/1947, at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15/1947 to 10/15/1947 and that I last saw h[illegible] alive on 10/15/1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Sinai Hosp Date signed 10/18/47

VS 150

G56152 BALTIMORE CITY HEALTH DEPARTMENT G56152
Registered No.

CERTIFICATE OF DEATH 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 S. Robinson St.
(c) Hospital or institution:
— None —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 1 —
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 S. Robinson St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country — — —

3 (a) FULL NAME Mary Mueller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John Mueller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-24-1868

8. AGE: Years	Months	Days	If less than one day
79	6	22	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name George Fortsch
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Germany

16 (a) Informant John Mueller - Husband
(b) Address 811 S. Robinson St.

17 (a) Burial (b) Date thereof 10-20-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lindy & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) 1947 (b) Filed by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16-47 1947, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9-1947, to 10-16-1947, and that I last saw h[illegible] alive on 10-15-1947.

Immediate cause of death	Duration
Hypertension C.V. Disease	
Due to Cerebral Thrombosis	7-9-47
Due to Puerperal Fracture	10-8-47
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation None
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Schoenrock M. D.
Address 842 S. Eaton Date signed 10-18-47

V S 150

G56153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G56153 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2045 Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1882

8. AGE: Years 65 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Emmitsburg, Pa.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Robert Clark
13. Birthplace Pa.

MOTHER
14. Maiden Name Anna Harding
15. Birthplace Pa.

16 (a) Informant Hospital Records
(b) Address Redwood & Greene Sts.

17 (a) Burial (b) Date thereof 11/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Anthony's
Location Emmitsburg, Md.

18 (a) Funeral director M. L. Creager & Son
(b) Address Thurmont, Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1947, at 6:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1947 to 10/18 1947, and that I last saw h[illegible] alive on 10/18 1947.

	Duration
Immediate cause of death Resp Failure ? Cardiac Failure	
Due to Metastasis	
Due to	
Other Conditions Widespread metastasis and spread. (Include pregnancy within 3 months of death)	

Date of operation —

Major findings of operation: —

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H N Taylor M. D.
Address Univ. Hospital Date signed 10/18

VS 150

G56154 BALTIMORE CITY HEALTH DEPARTMENT G56154

CERTIFICATE OF DEATH V164a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Brookland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PAUL RUSH

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-9557

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Catherine Licharawicz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1901

8. AGE: Years	Months	Days	If less than one day
46	4	1	hr. min.

9. Birthplace Pittsburgh, Pa. (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Thomas Rush
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Catherine Rush
(b) Address 3722- Brookland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) Oct 9 1947 (b) Huntington Williams Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16, 1947, at 6.30 PM

21. I certify that I took charge of the remains described above, held an Inspect. and Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation by hanging.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/16/47 at about 6.20 A M.
(b) Where did injury occur? 3722 Brookland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Hung self with rope in closet

23. Signature Gilbert G. Merrill M.D. Medical Examiner.
Date signed 10/17/47

X

G56155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G56155 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2021 Ashton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Ashton St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Burns

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/23/1859

8. AGE: Years	Months	Days	If less than one day
88	3	24	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Ireland

MOTHER 14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Miss Mary Burns
(b) Address 2021 Ashton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave. & Fayette St.
(c) Filed by registrar Huntington Williams, M.D. Registrar

OCT 19 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1947 to Oct 17 1947. and that I last saw h. alive on Oct 17 1947.

Immediate cause of death Uremia — Duration

Due to Nephritis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Wilbur Smith, Jr.
Address 1983 W. Balto. St. Date signed 10/18/47 M.D.

656156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 656156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 Winston Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Winston Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWIN HUDSON ROBINSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	253-597 A.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widower

6 (b) Name of husband or wife Frances V. Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1874

8. AGE: Years	Months	Days	If less than one day
73	8	17	hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)
10. Usual Occupation Retired Bldr. Inspector
11. Industry or business B. & O. R. R.

FATHER
12. Name Richard Robinson
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Elizabeth Howard
15. Birthplace Harford Co., Md.

16 (a) Informant Miss Emma M. Skillman
(b) Address 421 Winston Ave. 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian Cem.
Location Govans, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 20 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1947, at 11:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946, to Oct. 17 1947 and that I last saw him alive on Oct. 17 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to Arteriosclerosis	15 yrs.
Due to Hypertension	
Due to Endocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl D. Benson, M.D.
Address 5111 York Rd. Date signed 10/18/47

G56157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G56157

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-16 to 10-19
(e) Length of stay in Baltimore (yrs., mos., or days) Year

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balto
(c) City or town 1640 Roxton Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Silesky

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife LATE ISAAC
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace AUSTRIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name PAUL HEIMLICH
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name PAULINE BELL
15. Birthplace AUSTRIA

16 (a) Informant SAMUEL SILESKY
(b) Address 1640 ROXTON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory FINSHIE NESSIN
Location ROSEDALE

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1124-26 W NORTH AVE.

OCT 20 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19/47 1947, at 2.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1947 to 10/19 1947 and that I last saw h alive on 10/18 1947.

Immediate cause of death — Duration
Pulmonary Edema
Due to Ht failure
Due to Cor pulmonale
Other Conditions Tracheal Stenosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. Rachlin M.D.
Address Sinai Hosp. Date signed 10/20/47

G56158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56158 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3402 Oakfield Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Oakfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Weinkrantz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Pesach Gerber
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael Potts
15. Birthplace Russia

16 (a) Informant Mrs Irvin Abrams
(b) Address 3402 Oakfield Ave

17 (a) Burial (b) Date thereof Oct 20, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

OCT 20 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION 9.25

20. DATE OF DEATH October 18 1947, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 19 to 10/18 1947, and that I last saw h[illegible] alive on 10/18 19 47

Immediate cause of death	Duration
arteriosclerotic Heart disease	8 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Queen B Krug

Address 2320 Eutaw pl Date signed 10/21/47

X

G56159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Home for Incurables
(b) Street address 700 W. 40th St.,
(c) Hospital or institution:
Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 9 19
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs. 9 mos. 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 11, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Amanda Sunderland Rich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (d) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Edward L. Rich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1874

8. AGE: Years 73 | Months 6 | Days 0 | If less than one day hr. min.

9. Birthplace Ellicott City, Howard Co., Md.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Benjamin L. Sunderland
13. Birthplace Howard Co. Md.

MOTHER 14. Maiden Name Mary Gertrude Isaac
15. Birthplace Ellicott City, Md.

16 (a) Informant Jane L. Adamson - Supt. (Records)
(b) Address Home for Incurables

17 (a) Burial (b) Date thereof 10/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 OCT 20 1947 (b) Huntington Hillcrest Md
(Date filed by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1947 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 25th 1945 to Oct. 17th 1947 and that I last saw her alive on Oct. 17th 1947

	Duration
Immediate cause of death: Cerebral Hemorrhage	1½ days
Due to Hypertension and Arteriosclerotic Cardio Vascular Disease	15 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolff, M. D.
Address 11 E. Chase St. Baltimore 2 Maryland Date signed 10/21/1947

G56160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G56160 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8
(e) Length of stay in Baltimore (yrs., mos., or days) 10 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 E. NORTH AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES BERNARD COOPER

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-0975

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife VEDA MELISSA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/27/98

8. AGE: Years	Months	Days	If less than one day
49	5	21	hr. min.

9. Birthplace ANNAPOLIS, MD. (Town, county, and state)
10. Usual Occupation BAKER
11. Industry or business FOOD TRADE

FATHER
12. Name William V. Cooper
13. Birthplace Eastern Shore of Md.

MOTHER
14. Maiden Name Minnie DeLeon
15. Birthplace Phila. Pa.

16 (a) Informant WIFE-Veda M. Cooper
(b) Address 1832 E. NORTH AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff
Location Annapolis Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

1947 OCT 20 1947 Huntington Williams M.D. (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1947, at 8:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1947 to 10/18 1947 and that I last saw HIM alive on 10/18 1947

Immediate cause of death MASSIVE CEREBRAL HEMORRHAGE — Duration 7 Hrs.
Due to HYPERTENSION
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Honeska M.D.
Address St. Jos. Hosp. Date signed 10/18/47

G56161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G56161
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 433 S. Broadway
(c) Hospital or institution: 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 433 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Parker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 9th 1880

8. AGE: Years	Months	Days	If less than one day
67	7	8	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name (Unknown) Parker
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mary Parker
(b) Address 433 S. Broadway

17 (a) Burial (b) Date thereof 10/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Abington M.E. Church
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) OCT 20 1947 (b) [illegible]
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1947, at 5 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1947 to Oct 17 1947, and that I last saw him alive on Oct 16 1947

Immediate cause of death
(a) General Arteriosclerosis
(b) Chronic myocarditis

Duration
5 yrs
5 years

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Clifton L. Solomon
Address 129 S. Bway Date signed 10/18/47 M.D.

VS 150

G56162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56162
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6111 York Rd Dot
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 N. Wolfe
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Dressel Sr.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Matilda R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1889

8. AGE: Years 54 | Months 11 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles Dressel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Matilda Guress
15. Birthplace Baltimore

16 (a) Informant Mrs. Matilda R. Dressel
(b) Address 6111 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 21 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Parkwood

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (Date rec'd by registrar) OCT 20 1941 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1941, at 4:15 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 10/18/41

VS 181

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Maryland Hospital 12
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~, or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ANNA GRACE SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of husband: Charles Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar 31st 1895

8. AGE: Years 52 | Months 6 | Days 17 18 | If less than one day hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Thomas Davis
13. Birthplace: Md.

MOTHER
14. Maiden Name: Martha (Unknown)
15. Birthplace: Md.

16 (a) Informant: Charles Smith
(b) Address: 303 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Westfield
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 127 St. Paul St.

19 (a) OCT 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1947, at 12 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1947 to 10-18 1947, and that I last saw h~~er~~ alive on 10-17 1947.

Immediate cause of death: RESPIRATORY FAILURE — Duration

Due to: CARDIC DECOMPENSATION

Due to: HYPERTENSIVE CARDIO VASCULAR DISEASE

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John Gordon Mowat Jr. M. D.
Address: Md. Gen. Hosp. Date signed: 10-18-47

X

G56164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8/1a

Registered No. G56164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd. & Hemingway
(c) Hospital or institution: Lyden Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County
(b) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(c) Street No. 855 PARK AVE
(If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM T. THOMAS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 24, 1928

8. AGE: Years	Months	Days	If less than one day
18	9	24	hr. min.

9. Birthplace PORTSMOUTH OHIO
(Town, county, and state)

10. Usual Occupation ELECTRICIANS

11. Industry or business HELPER

FATHER
12. Name CHARLES F. THOMAS
13. Birthplace KENTUCKY

MOTHER
14. Maiden Name LUCY RUGGLES
15. Birthplace KENTUCKY

16 (a) Informant CHARLES F. THOMAS
(b) Address 855 PARK AVE BALTO

17 (a) Burial (b) Date thereof 10/21/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Pavl St.

19 OCT 20 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 18 1947, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1947, to Oct. 18 1947, and that I last saw h[illegible] alive on Oct 18 1947.

Immediate cause of death — Duration

Respiratory failure

Due to —

Due to Meningitis (Otitis ? undetermined) 4½ wks

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Edward A. Cooper M. D.
Address Lutherville Date signed

Hosp. + 18 Oct 1947

~~E56165~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C56465

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Hilken Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3335 West Belvedere St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary F. Le Compte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm. F. Le Compte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4th 1872

8. AGE: Years 75 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wallace Ars.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Sanders
15. Birthplace Balto. Md.

16 (a) Informant Elmer Le Compte
(b) Address 1432 Woodall St

17 (a) Burial (b) Date thereof 10/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 OCT 20 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19/47 19 , at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Oct 47 19 , to 19 Oct 19 47, and that I last saw her alive on 19 Oct 19 47

Immediate cause of death: Cerebro-Vascular Hemorrhage — Duration

Due to: Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James E. Hamill M.D.
M. D.
Address St Agnes Hosp. Date signed 10/20/47

G56166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

438806 142B

Registered No. G56166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 720 S.
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 S. Hanover St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME GOLDIE STARVIS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col	married

6 (b) Name of husband or wife Barnett Starvis
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 4-8-15

8. AGE: Years	Months	Days	If less than one day
32	6	9	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Grant Ingle
13. Birthplace Md.

MOTHER
14. Maiden Name Hannah Yetters
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Stamps
(b) Address 142 W. Hill St

19 (a) Oct 20 1947 (b) Date received by registrar Washington for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1947, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1947, to 10/17 1947 and that I last saw her alive on 10/17 1947.

Immediate cause of death: Extrauterine Pregnancy. Tubal Abortion. — Duration: 2 months

Due to

Due to

Other Conditions Nephritis, Chronic Hypertensive Cardio Vascular disease

(Include pregnancy within 3 months of death)

Date of operation Oct 18-1947.

Major findings of operation: Ectopic Pregnancy

of autopsy: Transfusion Kidneys.

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert P. O'Donnell

Address Johns Hopkins Hospital Balto Md Date signed Oct 17 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56163 340690 ✓14 Reg. No. 56467

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Denver St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ASLEE DUKES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/11/26

8. AGE: Years	Months	Days	If less than one day
21	7	6	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaac Dukes
13. Birthplace ?

MOTHER
14. Maiden Name Georgia Murray
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md
18 (a) Funeral director David L Brown & Son
(b) Address 106 W Montgomery St
19 (a) OCT 20 1947 (Registered by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1947, at 3.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1947 to 10/17 1947, and that I last saw h... alive on 10/17 1947.

Immediate cause of death ? Tuberculous meningitis — Duration 2 weeks
Due to
Due to
Other Conditions Bronchiectasis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature David Gottlieb M. D.
Address J H H Date signed Oct 20 '47

X

G56168 G56168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3919 Boarman Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Boarman ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Fannie Hausman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of husband or wife Fania Hausman

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) June 20, 1885

8. AGE: Years 59 | Months 3 | Days 28 | If less than one day ____ hr. — ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Myer S. Rosin
13. Birthplace Russia

MOTHER
14. Maiden Name Dina Rose Rosin
15. Birthplace Russia

16 (a) Informant Fania Hausman
(b) Address 3919 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Bel. Rd. & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) Oct 20 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947, at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Oct 18 1947, and that I last saw h.m. alive on Oct 18 1947.

Immediate cause of death Diabetes Mellitus — Myocarditis — Anemia — Duration

Due to —

Due to —

Other Conditions Acute cardiac dilatation

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Benj. J. Kadis M. D.

Address 2306 Eutaw Pl Date signed 10-19-47

G56169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G56169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument
(c) Hospital or institution: Sinai Hosp 12 Square Oct 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 Lakeview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Silverstein, Saul

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Rena Silverstein
(b) Address 2412 Lakeview ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Rogers Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 260 Eutaw Place

19 OCT 20 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1947, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1947 to 10/19 1947 and that I last saw h[illegible] alive on 10/19 1947.

Immediate cause of death: Pulmonary Embolism — Duration: minutes

Due to: Thrombophlebitis — 2 wks

Due to: Cancer of stomach with Brain Involvement

Other Conditions: date unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Rosenberg M.D. M. D.
Address Sinai Hosp Date signed 10/21/47

G56170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G56170 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. Rose St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH ROEBER ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles F. Roeber Jr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21-1906

8. AGE: Years 41 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name J. D. Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah Keller
15. Birthplace Balto. Md.

16 (a) Informant Charles F. Roeber Jr.
(b) Address 419 N. Rose St

17 (a) Burial (b) Date thereof Oct. 22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Lem.
Location North Ave. & Gay St.

18 (a) Funeral director John F. Miller
(b) Address 2334 Jefferson St.

19 OCT 20 1947 Clarington Williams M.D. Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19/47 19 8:45 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide Gas poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/19/47 8 A. M.
(b) Where did injury occur? 419 N. Rose St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Found with head in oven of gas stove

23. Signature John R Weiss M.D.
Medical Examiner.
Date signed 10/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656171 HEALTH DEPARTMENT—CITY OF BALTIMORE 656171

B.C. #2-91318 CERTIFICATE OF DEATH 1612

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hosp St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 1 da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Charles C. Wells Jr. If U. S. Veteran specify WAR

(a) Residence: No. 1805 Hannaska Ave St. Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) 18 Oct 47 5 Yrs

7. AGE Years	Months	Days	If LESS than 1 day hrs. or min.
			15

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Butte Mont
(State or country)

FATHER

13. NAME Charles Christian Wells

14. BIRTHPLACE (city or town) Butte Mont
(State or country)

MOTHER

15. MAIDEN NAME Virginia Juanita Webb

16. BIRTHPLACE (city or town) Butte Mont
(State or country)

17. INFORMANT Mother
(Address) 1805 Hannaska Ave

18. BURIAL, CREMATION, OR REMOVAL
Place [redacted] Oct 20 1947

19. UNDERTAKER John A. Miller
(Address) 2334 Jefferson St.

OCT 20 1947 Huntington Williams, Mgr.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 18 Oct 1947

22. I HEREBY CERTIFY, That I attended deceased from 18 Oct 1947 to 18 Oct 1947

I last saw him alive on 18 Oct 1947. Death is said to have occurred on the date stated above, at 8:25 p.m.

The principal cause of death and related causes of importance were as follows:

	Interval between Onset and Death
Diphtheria Gravis	

Other contributory causes of importance

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Clinical Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No If so, how?

(Signed) Charles Sc M.D.
(Address) 3214 Eutaw Pl

X

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G56172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 82a

Registered No. G56172

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3018 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 69 45 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry A. Knott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha Doyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25 1878

8. AGE: Years	Months	Days	If less than one day
69	-	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Contractor + Builder
11. Industry or business Own Business 2102 Chas St

FATHER
12. Name Frank A Knott
13. Birthplace Frederick Co. Md

MOTHER
14. Maiden Name Margaret Heran
15. Birthplace Md.

16 (a) Informant Mrs Martha Knott
(b) Address 3018 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3700 old Frederick Rd
18 (a) Funeral director Harry A. Witzke
(b) Address 410 Edmondson Ave
19 OCT 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1946, to 10-16 1947, and that I last saw h/m alive on 10-16 1947.

Immediate cause of death Cerebral accident — Duration
Due to Hypertension
Due to Generalized Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Louis Vogel J. M.D. M. D.
Address 701 E. Monument St. Date signed 10-18-47

X

656173 LW 114405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 656173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Pearson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M2	W	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15/1885

8. AGE: Years	Months	Days	If less than one day
62	9	-	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robart
13. Birthplace Md.

MOTHER
14. Maiden Name Julia
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gunpowder Neck Rd.

18 (a) Funeral director John J. Fahey & Sons
(b) Address 1818 Light St.

OCT 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. - 15 1947, at 7:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1947, to Oct. 15 1947 and that I last saw h im alive on Oct. 15 1947

Immediate cause of death	Duration
Cardiac failure	
Due to Myocardial infarction	
Due to Hypertensive C-V Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy No chance

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William H. Vinbury M.D.
Address Balt. City Hosp. Date signed M Oct 17 D 47

C56174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. C56174

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Green & Lombard St.
(c) Hospital or institution: University Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) Couple Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 Chesterfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Hughes Rountree (ROUNTREE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Mr. James Rountree

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Nov 8-1895

8. AGE: Years 51 | Months 11 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Mary Queen Queens County Island (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name (Unknown) Hughes
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. James Rountree
(b) Address 3509 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 OCT 20 1947 (Date rec'd by registrar) (By) Arlington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6:30 PM 1947, to 6:40 P.M 1947 and that I last saw h alive on 10-17-1947

Immediate cause of death Acute congestive cardiac failure — Duration

Due to — Duration

Due to — Duration

Other Conditions None — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard E. Dull M. D.
Address University Hosp. Date signed 10-12-47

Advised by Medical Examiner Howard E. Dull, MD

G56175

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G56175
Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death, clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Queen Anne's
(c) City or town CHURCH HILL MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRIETTA C BRIERLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: H. G. BRIERLEY

6 (c) If alive, give age: DEAD years

7. Birth date of deceased (mo., day, yr.) APRIL 13 1870

8. AGE: Years 77 | Months 6 | Days 8 | If less than one day ....hr. ....min.

9. Birthplace QUEEN ANNS Co. MD.
(Town, county, and state)

10. Usual Occupation Home duties

11. Industry or business

FATHER
12. Name C. W. CLASH
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ELLEN ANDERSON
15. Birthplace MARYLAND

16 (a) Informant MRS ELIZABETH WILLIAMS
(b) Address 338 WINSTON AVE. BALTIMORE MD

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct 26/47 (month) (day) (year)
(c) Cemetery or crematory Centreville Cemy.
Location Centreville Md

18 (a) Funeral director John O. Mitchell Funl
(b) Address 1400 Eutaw Place

OCT 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1947, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to Oct 15 1947, and that I last saw her alive on Oct 15 1947.

Immediate cause of death: Congestive heart Failure — Duration: 5 Days

Due to: Coronary Thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel G Brierley
Address Union Memorial Hospital Date signed 10/20/47

G56176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registration No. G56176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type or print. Underline the cause of death which is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 W Lombard St
(c) Hospital or institution: ✓ 18 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country ✓

3 (a) FULL NAME Katherine K Haines

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank F. Haines

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28th 1874

8. AGE: Years	Months	Days	If less than one day
73	7	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name Joseph Rosensteel
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mrs Frank F Haines
(b) Address 1012 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/47 (mo.) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Gannon & Son
(b) Address 904-07 Hollins St

19 OCT 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17th 1947, at 8:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 19 47 to 10/17 1947.
and that I last saw h.e.r. alive on 10/17 19 47

Immediate cause of death: Pulmonary Congestion — Duration: 2 days
Due to: Hypertensive Cardiov Vascular Disease — Duration: 6 yrs
Due to — Duration:
Other Conditions — Duration:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Johns P. Urbach, Jr. M.D.
Address 1227 Wash Blvd Date signed 10/18/47

V S 190

X

G56177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ G56177 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bello City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mo 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Lyndale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Leinweber

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-1044

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Marian Leienmeber
6 (c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) July 9 1885

8. AGE: Years	Months	Days	If less than one day
62	3	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Heyer Bros

FATHER
12. Name Aug Leienmeber
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Kate Leienmeber
(b) Address 3306 Lyndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2005 Orleans St.

OCT 20 1947 (Date rec'd by registrar) Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1947, at 10 20 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. [illegible] M.D. Medical Examiner.
Date signed 10/18/47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C56178 D14437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 13B

Registered C56178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 Poplar Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Byer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2- 1885

8. AGE: Years 62 | Months 6 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Byer
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Cline
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem. City
Location

18 (a) Funeral director Ulrich's Funeral Home
(b) Address 2006 Orleans St.

19 (a) OCT 20 1947 (Date received by registrar) (b) Registrar

VS 150 ....

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1947 at 8.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11- 1947, to 10-18 1947, and that I last saw him alive on 10-18 1947

Immediate cause of death	Duration
Tuberculosis of Lungs, For advanced	10yrs?
Due to	
Due to	
Other Conditions Congestive Heart Failure, Arteriosclerotic CV. (Include pregnancy within 3 months of death)	2 wks

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh W. Parlow M. D.
Address Balt City Hosp. Date signed 10-18-47

X

G56179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56179

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1921 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Pappas = Mitchell = Pappamichael

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-17-6977

4. Sex: MALE

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Eleanor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23- 1881

8. AGE: Years 65 66 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace: Greece (Town, county, and state)

10. Usual Occupation: Cook

11. Industry or business

FATHER
12. Name: James Pappamichael
13. Birthplace: Greece

MOTHER
14. Maiden Name: Katherine —
15. Birthplace: Greece

16 (a) Informant: William Mitchell - Son
(b) Address: 108 Montrose Ave - Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21- 47 (month) (day) (year)
(c) Cemetery or crematory: Meadow ridge Cem
Location: Md

18 (a) Funeral director: Lott & B. M. Walter
(b) Address: Pratt & Eutaw Sts

Oct 20 1947 (Date rec'd by registrar) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1947, at 10 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1947 to Oct. 18 1947, and that I last saw him alive on Oct. 17 1947.

	Duration
Immediate cause of death: Asthma bronchitis heart failure	?
Due to: Paralyzed arteriosclerosis	?
Due to: Age —	
Other Conditions: —	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: M. B. Mitchell M. D.
Address: 54 S. Fulton Ave. Date signed 10-18-47

VS 150

G56180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111 B

G56180

Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY JACKSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Henry Jackson

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace King Williams Co. Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Henry Jackson
(b) Address 1520 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Cleon S. Wilson
(b) Address 1010 Bibbitty ave

OCT 20 1947 (Date received by registrar) Hunting Town Williams Va

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1947, at 1.25 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 10-17-47

G56181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 173

G56181 Registered No.

PRINT. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen'l Hosp 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dom
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul E Dahms

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 17, 1924

8. AGE: Years 23 | Months 5 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Emily Dahms
13. Birthplace Germany

MOTHER 14. Maiden Name Minnie Bernd
15. Birthplace New York

16 (a) Informant Mr Emil Dahms
(b) Address 3701 Hudson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20 47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director L. Heemann Sr
(b) Address 6067 Harford Rd

19 (a) OCT 20 1947 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Eugene Young Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: A.A.

(a) Date of injury Oct 18, 1947 at 5:00 P.M.
(b) Where did injury occur? Shoemaker Field, Woodyard
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place (While at work?) No
(d) Means of injury Airplane crash accident

23. Signature William F Kelly M.D.
Medical Examiner.
Date signed Oct 19, 1947

VS 181

G56182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G56182 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 Thomas Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham FISHER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Goldie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Sylvia
15. Birthplace Russia

16 (a) Informant Goldie Fisher
(b) Address 1636 Thomas Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philad'a + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eastern Place

19 (a) Oct 20 1947 (Date received by Registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19, 1947 at 9.20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease
Acute bronchitis.
Due to History of diabetes

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 10/20/47

656183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registration No. 656183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 S Clinton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 S. Clinton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elida Jansen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife John A. Jansen (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) September 5, 1878

8. AGE: Years	Months	Days	If less than one day
69.	1	11	hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Ernest Gudiksen
13. Birthplace Norway

MOTHER
14. Maiden Name Maria Stejones
15. Birthplace Norway

16 (a) Informant John A. Jansen
(b) Address 419 S. Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave. Balto.

18 (a) Funeral director Wendell Wippel
(b) Address 312 S. Highland Ave

OCT 20 1947 (Date rec'd by Registrar) Huntington Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 16 - 1947, at 4:10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3-1944 to 10-16-1947 and that I last saw her alive on 10-16-1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 hrs
Due to Chr. arteria Sclerosis	3 yrs +
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. J. Davis M. D.
Address 3218 Eastern Ave Date signed 10-18-47

VS 150

G56184 D.C. #47-9759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G56184 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST.
(c) Hospital or institution: MERCY HOSPITAL 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 HRS
(e) Length of stay in Baltimore (yrs., mos., or days) 3 HRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 HOLLINS ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME BABY BOY GREENWAY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	NEWBORN

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/47

8. AGE: Years	Months	Days	If less than one day
			3 hr. 50 min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name WILLIAM GREENWAY
13. Birthplace HENDERSON, N.C.

MOTHER
14. Maiden Name FRIEDA STEWART
15. Birthplace N. CAROLINA

16 (a) Informant MOTHER
(b) Address 1300 HOLLINS ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-47 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director George A Farley
(b) Address Fulton Ave & Fayette St

19 (a) OCT 20 1947 (Date rec'd by registrar) (b) Huntington Williams Hall

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 19 1947, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 19 1947 to OCT 19 1947, and that I last saw him alive on OCT 19 1947.

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to COMPLETE ATELECTASIS OF LEFT LUNG.

Due to CONGENITAL CARDIAC ANOMALIES

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elden H. Perry M. D.
Address Mercy Hosp. Date signed 10/19/47

VS 150

G56185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56185 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4104 Dorchester Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4104 Dorchester Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Emma Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William Z Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1866

8. AGE: Years	Months	Days	If less than one day
81	3	25	hr. min.

9. Birthplace Cadiz, Ohio (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Velmer G. King
(b) Address 4104 Dorchester Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21, 47 (month) (day) (year)
(c) Cemetery or crematory Union
Location Port Washington, Ohio
18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Hghts Ave.
OCT 20 1947 (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947 at 10:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 9 1937 to Oct 18 1947, and that I last saw her alive on Oct 17 1947

Immediate cause of death	Duration
Chron. myocarditis -	5 yrs
Due to Arteriosclerosis	15 yrs
Due to	
Other Conditions Chronic Cholecystitis -	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edw. S. Edel M. D.
Address 3403 Garrison Blvd Date signed

X

G56186 HOEPNER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Weaver Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3025 Weaver Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elise Hoepner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Theodore B. Hoepner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3, 1863

8. AGE: Years	Months	Days	If less than one day
83	11	15	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER 12. Name Gerhardt Wesselman
13. Birthplace Germany

MOTHER 14. Maiden Name Adelaide Hulscher
15. Birthplace Germany

16 (a) Informant Pauline Hoepner Bell
(b) Address 3025 Weaver Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mrs. John W. Geisel & Son
(b) Address 5311 Edmondson Ave

19 OCT 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1947 to Oct 18 1947 and that I last saw HER alive on Oct 17 1947.

Immediate cause of death: Bronchopneumonia — Duration 4 days
Due to Arteriosclerotic Heart Disease — Duration unknown
Due to Generalized Arteriosclerosis — Duration unknown
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irvin Darrah M. D.
Address 4808 Harford Rd. Date signed 10/18/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G56187

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1641 N. Appleton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 N. Appleton St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Jenkins

3 (b) If veteran, name war: WWI

3 (c) Social Security Account No. 212-07-8279

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lillian Jenkins

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 8-5-04

8. AGE: Years 43 | Months 2 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Annadosta, D.C.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Ft. Howard Hosp.

FATHER
12. Name James Jenkins
13. Birthplace Va

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Lillian Jenkins
(b) Address 1641 N. Appleton St

17 (a) Burial (b) Date thereof 10-21-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Berts. Nat. Cem.
Location Frederick Ave.

18 (a) Funeral director Charles L. Law
(b) Address 802 Mad. Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

OCT 20 1947

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947, at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1947 to Oct 18 1947 and that I last saw h[illegible] alive on Oct 18 1947.

Immediate cause of death: Coronary Thrombis — Duration

Due to: —

Due to: —

Other Conditions: —
(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury

23. Signature Julian S. Wheeler M. D.

Address 1802 Penna Ave Date signed 10-20-47

X

G56188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G56188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3107 Virginia Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Virginia Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Nooney,

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Austin D. Nooney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1884

8. AGE: Years	Months	Days	If less than one day
63	4	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business at home

FATHER
12. Name Adam Rauh,
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name ~~Klein~~ Cora Smith,
15. Birthplace unknown

16 (a) Informant Mrs. Charles L. Klein,
(b) Address 3107 Virginia Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore City.

18 (a) Funeral director H. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 OCT 20 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1947, at 8:1 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 29 47 to Oct 16 19 47.
and that I last saw h-- alive on 19 .

Immediate cause of death Carcinoma Lung — Duration 1 Yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Carcinoma of Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Feuer
Address 11 E. Chase St Date signed 10/20/47

VS 150

G56189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G56189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-14 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1/2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Thomas S. Hawkins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race Negro
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Beatrice B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14, 1869

8. AGE: Years 77 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Annapolis Md. (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Beatrice B. Hawkins
(b) Address 1202 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal)? (b) Date thereof Oct. 20, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Hallam
(b) Address 1631 Druid Hill Ave

19 (a) OCT 20 1947 (Date received by registrar) Huntington Williams Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1947, to 10/17 1947, and that I last saw h[illegible] alive on 10/17 1947

Immediate cause of death Carcinomatosis — Duration ?
Due to Ca. of Prostate
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address Date signed

VS 150

G56190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1118

Registered No. G56190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Belle Vaughn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Curtis Vaughn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1903

8. AGE: Years 44 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Chesterfield Co., Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Thomas
13. Birthplace Chesterfield Co. Va.

MOTHER
14. Maiden Name Ida Thomas
15. Birthplace Chesterfield Co. Va.

16 (a) Informant Curtis Vaughn
(b) Address 412 N. Mount St.

17 (a) Shipped (b) Date thereof Oct. 20 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Chesterfield Co. Va.

18 (a) Funeral director Mrs. Peter Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 20 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1947, at 6:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13/1947 to 10/17/1947 and that I last saw her alive on 10/17/1947

Immediate cause of death Gastric Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Taylor

Address 1522 Harlem Ave. Date signed 10/18/47

G56191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G56191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5195 Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/1/67.

8. AGE: Years 80 | Months 5 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Margaret Stevens
(b) Address 5195 S. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director Kelly & Leibrandt
(b) Address 403 36 Wolfe Street

19 (a) OCT 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Huntington Williams M.D.
Medical Examiner.
Date signed Oct 18, 1947

G56192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Powers St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Russell

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-7733

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife May D. Russell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1885

8. AGE: Years	Months	Days	If less than one day
62	9	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Asst. Station Agt.
11. Industry or business Railroad Freight Station

FATHER
12. Name William Thomas Russell
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Ellen Burk
15. Birthplace Baltimore

16 (a) Informant Mrs. May D. Russell
(b) Address 829 Powers Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21-1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director L. Durgin Funeral Home
(b) Address 303 Fells Road

19 (a) OCT 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1947, at 8:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1947 to 10/18 1947; and that I last saw h[illegible] alive on 10/18 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Marked Cardiac Degeneration	
Due to Hypertension with Cerebro-Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Burkhart
Address Md. Gen'l Hosp. Date signed Oct. 18, 47

VS 150

G56193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G56193

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Mercy Hosp 26 E Fayette
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) unk.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 5413 KNELL Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES KINCHLER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife [redacted]
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) (Month) 11-6-1900

8. AGE: Years 46 | Months 11 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER 12. Name James Kinchler
13. Birthplace England

MOTHER 14. Maiden Name Catherine Doran
15. Birthplace Penna

16 (a) Informant Mrs. Margaret M. Kinchler
(b) Address 5413 Knell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd & Moravia Ave

18 (a) Funeral director Leonard J. Rueb
(b) Address 5305 Harford Rd

19 (a) OCT 20 1947 (b) [illegible] Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17 1947, at 1030 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1947 to 19 ; and that I last saw h alive on 10-17 1947

Immediate cause of death Resp failure — Duration unkn

Due to Subarachnoid Hemorrhage — 6 hrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Buchner M. D.
Address Mercy Hosp Date signed 10-7-47

VS 150

G56194

BALTIMORE CITY HEALTH DEPARTMENT X 52a

CERTIFICATE OF DEATH

Registered No. G56194

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Shadyside (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Bernard Varnell Nich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-3-44

8. AGE: Years	Months	Days	If less than one day
3 yrs	-	16	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Leonard Nicta
13. Birthplace Maryland

MOTHER
14. Maiden Name Eunice Nich
15. Birthplace Maryland

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct 31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Ignatius
Location Shadyside Md

18 (a) Funeral director J.B. Thyson
(b) Address Annapolis

1947 OCT 20 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1947 at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1947 to Oct. 19 1947, and that I last saw h[illegible] alive on Oct. 19 1947

Immediate cause of death	Duration
Cerebral Vascular accident	
Due to Neuroblastomata, Both Kidneys	
Due to	
Other Conditions Metastases & long bones	

(Include pregnancy within 3 months of death)
Date of operation 10-10-47
Major findings of operation: Tumors Both Kidneys
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature J. Neil Lysaught M. D.
Address Johns Hopkins Hosp. Date signed Oct 9, 1947

J. Neil Lysaught

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 94a

Registered No. G56195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3045 W North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 6
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3045 W North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Mason Damaron

3 (b) If veteran, name war

3 (c) Social Security Account No. 1065-09-3456

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W.

6 (b) Name of husband or wife Anna S. Damaron
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1882

8. AGE: Years	Months	Days	If less than one day
64	9	27	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name Rev. Charles L. Damaron
13. Birthplace Va.

MOTHER
14. Maiden Name Catherine Allen
15. Birthplace Va.

16 (a) Informant Mrs. James S. Rennie
(b) Address 3321 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. Howard Storey
(b) Address 3207 W. North Ave.

19 (a) Oct 20 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947, at 1:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature William J. Mc Glade M.D. Medical Examiner
Date signed Oct 19, 1947

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157H

G56196

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Elevation (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES DEWEY SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/20/47

8. AGE: Years | Months: 2 | Days: 29 | If less than one day: hr. min.

9. Birthplace A.A. Co (Elvaton) (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Smith
13. Birthplace Penn.

MOTHER
14. Maiden Name Doris M. Beatty
15. Birthplace Baltimore

16 (a) Informant Robert Smith
(b) Address Elvaton, AA. Co.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A.A. Co Md.

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E. Fort Ave

19 OCT 20 1947 Huntington Williams, M.D. (Date rec'd by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1947, at 6.10 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxia

Due to: Aspiration of vomitus

Other Conditions: Congenital malformation of kidneys
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10-18-47

G56197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

120 B

Registered No. G56197

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Georges
(c) City or town Suitland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4713 Nannie Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Bryant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annual

6 (c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): 1921

8. AGE: Years: 26 | Months: — | Days: — | If less than one day: ___ hr. ___ min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or Business

FATHER
12. Name: Joseph Shipton
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Lois Carroel
15. Birthplace: Pa.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 10/20/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: Washington Nat. Park
Location: Washington D.C.

18 (a) Funeral director: [illegible]

(b) Address [illegible]

19 (a) OCT 20 1947 (b) [illegible]
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-19-1947 at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1947 to 10-19 1947 and that I last saw her alive on 10-19-1947.

	Duration
Immediate cause of death: Peritonitis	
Due to: Ulcerative Colitis	1 year
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Douglas Gould

Address: Johns Hopkins Hosp. Date signed: 20 Oct 1947

X

656198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registration No. 656198

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Turner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 190

8. AGE: Years	Months	Days	If less than one day
47	-	8	hr. min.

9. Birthplace Charles Co. Md. (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Thomas Turner
13. Birthplace Charles Co. Md.

MOTHER
14. Maiden Name Hattie Day
15. Birthplace Charles Co. Md.

16 (a) Informant Mrs. Pearl Price
(b) Address 1425 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 19 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Wm. Chas. H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) Date received by registrar OCT 21 1947 (b) Registrar Huntington Williams, M.D.

VS 190[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1947; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1947 to 10/18 1947, and that I last saw h[illegible] alive on 10/18 19 47

Immediate cause of death Congestive Heart Failure

Due to Myocardial Infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration
4 days
7
*

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M.D.
Address 1514 Division St. Date signed 10/18/47

G56199 B# 988343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G56199 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 S. Broadway
(c) Hospital or institution: The Johns Hopkins Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5330 Denmore Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Reddicks (410071)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1947

8. AGE: Years	Months	Days	If less than one day
	1	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Melvin Reddicks
13. Birthplace West Virginia

MOTHER
14. Maiden Name Lillian Tunney
15. Birthplace West Virginia

16 (a) Informant Mrs. Stephanie Reddicks
(b) Address 5330 Denmore Ave

17 (a) Burial (b) Date thereof Oct 21, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Asbury Mem. Pk
Location Balto. Co. Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1631 Druid Hill ave.

OCT 21 1947 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1947, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1947, to Oct. 17 1947, and that I last saw h... alive on Oct. 17 1947.

Immediate cause of death Multiple congenital deformities — Duration

Due to Congenital heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. Williams M. D.
Address Johns Hopkins Hospital Date signed 10-20-47

X

G56200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G56200 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3211 E. Baltimore
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 E Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Sophia Rosenberger

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Harry L. Rosenberger | 6 (c) If wid., give age 66 years

7. Birth date of deceased (mo., day, yr.) June 22-1884

8. AGE: Years 63 | Months 3 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name John Hirt
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Reiger
15. Birthplace Germany

16 (a) Informant Harry L Rosenberger
(b) Address 3211 E Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul st.

19 OCT 21 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1947, at 2.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1945 to Oct 19 1947, and that I last saw him alive on Oct 17 1947.

Immediate cause of death Carcinoma of Ovaries with Ascites

	Duration
Due to fistula.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Aug 13-1945

Major findings of operation: Carcinoma of Ovaries.

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Brown M.D.

Address 1663 W. Fort E. Date signed 10/19/47

VS 150

G56201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G56201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6010 Reisterstown Rd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Edna B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1885

8. AGE: Years	Months	Days	If less than one day
62	3	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired Lumber dealer

11. Industry or business Own

FATHER
12. Name John Campbell
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ella Wellings Lord
15. Birthplace Baltimore

16 (a) Informant Elsa G. Campbell
(b) Address 6010 Reisterstown Rd

17 (a) Burial (b) Date thereof 10/22/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

OCT 21 1947 (a) (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1947, at 8:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 1947 to Oct 19 1947, and that I last saw him alive on Oct 19 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Bronchogenic Carcinoma	
Due to	
Other Conditions Arteriosclerosis Lobar Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Burkhart M. D.
Address Md. Gen. Hospital Date signed 10/19/47

G56202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G56202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
Street No. 929 Washington Blvd
(If rural give location)
(c) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Grazulis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Lith
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant Joseph Miller
(b) Address 929 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Fulton & Ludlow Rd

18 (a) Funeral director Joseph Kasmakes
(b) Address 602 Washington Blvd

OCT 21 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Oct 1947, at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 June 1947 to 18 Oct 1947 and that I last saw h[illegible] alive on 18 Oct 1947

Immediate cause of death Cerebro-Vascular Renal Disease — Duration 1 yr.

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Edward F Milan M.D.
Address 602 Washington Blvd Signed 20 Oct 1947

G56203 JL - 67935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30C

G56203 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 2612
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ? Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gaither Surrett

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife Gracie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
51 ?			hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jake Surrett
13. Birthplace S. C.

MOTHER
14. Maiden Name Harriet ?
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 20, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 21 1947 (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 19 47 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2 1941 to Oct. 12 1941 and that I last saw h im alive on Oct. 12 19 47

Immediate cause of death	Duration
Cerebral Paresis	15 yrs
Due to C. N. S. Lues	25 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius Stolt, Jr. M. D.
Address Balt City Hosp Date signed 10/17/47

G56204 B.C 9-9/821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/61a

G56204 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 W. Fayette St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 W. Fayette St (If rural give location)
(e) Citizen of foreign country? Nos (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Grafton Allenbaugh Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-17-47

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business —

FATHER
12. Name Leonard Grafton Allenbaugh
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katherine May Rollins
15. Birthplace Baltimore

16 (a) Informant Leonard Allenbaugh
(b) Address 1621 W. Fayette St.

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 21 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1947, to Oct 18 1947, and that I last saw him alive on Oct 17 1947

Immediate cause of death: Asphyxia Neonatorum. — Duration 24 hrs.

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Eagle M. D.
Address Lying-In Hospital Date signed 10/19/47

Baltimore, Md. X

G56205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56205 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank HASSEL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER: 12. Name
13. Birthplace

MOTHER: 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

(c) OCT 21 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6, 1947, at 10.25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 10/6/47

G56206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. G56206

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 328 S. Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 S. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Richard B. Twisdale TWISDALE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Daisy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1899

8. AGE: Years 48 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace New York City (town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Richard Twisdale
13. Birthplace New York

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace New York

16 (a) Informant Daisy Twisdale
(b) Address 328 S Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Rest
Location New York

18 (a) Funeral director A. Palatead
(b) Address 918 Druid Hill Ave.

OCT 21 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1947 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1947 to 10/20 1947, and that I last saw h[illegible] alive on 10/17 1947.

Immediate cause of death: Cardio-Vascular Renal Disease

Duration

Due to Hypertension Years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. A. Jackson

Address 608 Washington Ave Brooklyn 18 N. Y. 10/20/47

V S 190

G56207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G56207
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 5 22

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 940 Leadenhall St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman White

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 52 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Port Authur Texas
(Town, county, and state)

10. Usual Occupation Cook
11. Industry or business Restaurant

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Nannie White
15. Birthplace ?

16 (a) Informant Mrs Lillie Laney
(b) Address 940 Leadenhall St

17 (a) Burial (b) Date thereof 10-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Ct
Location A. A. Co., Md

18 (a) Funeral director Isaac L Bramble
(b) Address 106 W Montgomery St

19 OCT 21 1947 Hunting for Williams, M.D.
(Date rec'd by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1947, at 6.45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. C. Lubinski M.D.
Medical Examiner.
Date signed 10/20/47

G56208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

23825-9 032 13B

G56208 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col.	widower.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-15-81

8. AGE: Years	Months	Days	If less than one day
66	2	25	hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name James Richmond

13. Birthplace ?

MOTHER 14. Maiden Name Julia ?

15. Birthplace ?

16 (a) Informant records

(b) Address JOHNS HOPKINS HOSPITAL

17. (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Loc[illegible] Medical School OCT 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 Oct 21 1947 (Date filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1947, at 1 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25-1947 to 10-9-1947 and that I last saw h[illegible] alive on 10-9-1947

Immediate cause of death Respiratory failure — Duration

Due to Miliary Tuberculosis — Duration 2wks

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Mason M.D.

Address Johns Hopkins Hosp. Date signed 10 Oct '47

X

G56209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G56209 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 W Conway St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 W Conway St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Sanders

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Charles Sanders
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25, 1896

8. AGE: Years 54 | Months 9 | Days 23 | If less than one day ___ hr. ___ min.

9. Birthplace Danville Pittsylvania Co Va
(Town, county, and state)

10. Usual Occupation House Wife
11. Industry or business

FATHER 12. Name Woodson Owens
13. Birthplace Danville Va

MOTHER 14. Maiden Name Ethel Peters
15. Birthplace Danville Va

16 (a) Informant Charles Sanders
(b) Address 502 W. Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20, 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore County Md

18 (a) Funeral director Joseph A Sivley
(b) Address 66 West Lane Street

OCT 21 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947, at 8 00 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH.

Carcinoma of the stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S Helfrich M.D. (Medical Examiner)
Date signed Oct 19, 1947

656210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 656210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Chambersburg (If outside city or town limits write RURAL and give town)
(d) Street No. 704 Lincoln Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barrette W. Ford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jean Ford (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 4-19-86

8. AGE: Years 61 | Months 6 | Days 1 | If less than one day ___ hr. ___ min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel Ford
13. Birthplace Md.

MOTHER 14. Maiden Name Maria Houpt
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 10/21/47 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Chambersburg Pa.

18 (a) Funeral director Wm. J. Dickson Sons
(b) Address North St.

19 (a) 10-21-1947 (b) Hunting for Williamsport Md
(Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20-47 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-47 to 10-20-47. and that I last saw alive on 10-20 1947.

Immediate cause of death: Cholemia — Duration 3 days

Due to: Laennec's cirrhosis of the liver — ? years

Due to:

Other Conditions: Pneumococcosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Laennec's cirrhosis; pneumococcosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry C. Markley M. D.
Address Johns Hopkins Hosp. Date signed 10/20/47

X

G56211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56211
Registered No.

PLEASE—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A.
(c) City or town Morley Neck Road
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Thalberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14. 1922

8. AGE: Years 24 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Air Craft Mechanic

11. Industry or business

FATHER
12. Name Michael Thalberg
13. Birthplace Europe

MOTHER
14. Maiden Name Anastasia Hallikas
15. Birthplace Europe

16 (a) Informant Mrs Anastasia Thalberg
(b) Address Stony Creek Rd. A.A.Co. Md

17 (a) Burial (b) Date thereof 10-22-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director Flippo & Flynn
(b) Address 1476 Light St.

19 OCT 21 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1947, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Aug Ex Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: a.a. Co.
(a) Date of injury Oct 18, 1947 at 5:20 P.M.
(b) Where did injury occur? Shawsher Field, Morley N.
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work? No
(d) Means of injury Airplane accident

23. Signature William J. Kilpatrick M.D.
Medical Examiner.
Date signed Oct 19, 1947

VS 151

G56212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56212 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3336 Elmora Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3336 Elmore Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Mangloin

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	8	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Walter Niederwemmer
(b) Address 3336 Elmora Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/37 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. end North Ave.

18 (a) Funeral director Martin W. E. Deppe's Sons
(b) Address Lanvale and Arun Sts.

19 (a) Oct 21 1937 (Date rec'd by Registrar) Huntington Williams M.D.

VS 180- ...-A

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1937, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 44 to Oct 19 37, and that I last saw h alive on Oct 19 37.

Immediate cause of death	Duration
Acute heart failure	
Due to Arteriosclerosis	
Due to Cardio-Vascular disease	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. B. Stevens M.D.
Address 3400 Eastern Ave Date signed 10/20/37

G56213 B.C.# 3-9-1933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 159

G56213 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 871 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 871 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roger D Davis / Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-16-47

8. AGE: Years | Months | Days 5 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Carl Davis
13. Birthplace Charleston S.C.
14. Maiden Name Effie Lee Bryant
15. Birthplace Elkton, Md

16 (a) Informant Carl Davis
(b) Address 871 Harlem ave.

17 (a) Burial (b) Date thereof Oct 22 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave

19 OCT 21 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1947 at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1947 to 10-18 1947 and that I last saw h alive on 10-18 1947

Immediate cause of death Acute Gastritis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Wilson M.D.
Address 871 Harlem Ave Date signed 10-20-47

G56214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G56214
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JAMES G. COBB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1913

8. AGE: Years 30 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Kinston North Carolina
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business Sparrow Point

FATHER 12. Name Marcellous Cobb

13. Birthplace North Carolina

MOTHER 14. Maiden Name Eva Pope

15. Birthplace Spring Hope N.C.

16 (a) Informant Eva Stewart

(b) Address 112 Cawer Rd Dundalk Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22, 1947 (month) (day) (year)

(c) Cemetery or crematory Balto. National Cem.

Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Baltimore ave

19 OCT 21 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1947, at 2.50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet-wound of chest, and abdomen, and liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-18-47 1.30 a. M.

(b) Where did injury occur? 1121 N. Wolfe St (Tavern)

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Firearms

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 10-18-47

G56215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G56215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DIA
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Pack

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Jason A.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation H. Wife

11. Industry or business

FATHER 12. Name James Gray
13. Birthplace Md

MOTHER 14. Maiden Name Minnie Hawkins
15. Birthplace Md

16 (a) Informant Jason A. Pack
(b) Address 1338 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/47 (month) (day) (year)
(c) Cemetery or crematory Cooper Chapel
Location Calvert Co. Md

18 (a) Funeral director H. B. Kelson
(b) Address 130 Presstman St

19 OCT 21 1947 (Date rec'd by registrar) (b) Huntingtor Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19/1947 at 4:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Stomach

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. B. Kelson M.D. Medical Examiner.
Date signed 10/20/47

G56216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town TURNERS STATION (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Stevenson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JULIA TURNER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife W
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 | 19 | 97

8. AGE: Years	Months	Days	If less than one day
50	1	29	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Sam Brafton
13. Birthplace Va

MOTHER
14. Maiden Name Cora —
15. Birthplace Va

16 (a) Informant James Turner
(b) Address 1309 Beach Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 | 20 | 47 (month) (day) (year)
(c) Cemetery or crematory Victoria
Location Victoria, Va

18 (a) Funeral director Geo. H. Kelson
(b) Address 1363 Pennsylvania Ave

19 OCT 21 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 OCTOBER 1947 at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Oct 1947 to 18 Oct 1947 and that I last saw he alive on 18 Oct 1947

Immediate cause of death — Duration
ACUTE MYOCARDIAL INFARCTION
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: NONE DONE
of autopsy: NONE DONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert B. Bauer M. D.
Address University Hosp Date signed 10-20-47

G56217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G56217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. correct age is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp
(c) Hospital or institution: 1514 Division St. 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wk
(e) Length of stay in Baltimore (yrs., mos., or days) 95 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 W Lanvale (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Laura N aters

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband ~~or wife~~ Upshur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-1870

8. AGE: Years 77 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Pocomoke City, Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name John Waters
13. Birthplace Md.

MOTHER 14. Maiden Name Harriet Waters
15. Birthplace Md.

16 (a) Informant Maggie Tyner (D)
(b) Address 804 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-47 (month) (day) (year)

(c) Cemetery or crematory Western Star Cem.
Location Balto County, Md.

18 (a) Funeral director Chas H Harper
(b) Address 510-12 N. Carrollton Ave

19 (a) Oct 21 1947 (month day year) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18/47 19... 10:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4/47 19... to 10/18/47. and that I last saw h alive on 10/18/47

Immediate cause of death: Pulmonary embolism — Duration

Due to

Due to

Other Conditions: Fracture left hip.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 17/3
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Oct. 3, 1947 at 2 P.M.
(c) Where did injury occur? 804 W. Lanvale St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Slipped and fell down stairs

23. Signature Ann Robinson
Address Provident Hosp Date signed 10/21/47 M.D.

Howard J. Madden, M.D. X

VS 150

G56218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use no abbreviations. Do not write above or below the lines. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 N. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Brayton.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Charles Brayton.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1890

8. AGE: Years	Months	Days	If less than one day
57	6	8	hr. min.

9. Birthplace Middlesex Co. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Burrell.
13. Birthplace Middlesex Co. Va.

MOTHER
14. Maiden Name Fannie Burrell.
15. Birthplace

16 (a) Informant Mrs. Elizabeth Mason.
(b) Address 913 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-1947 (month) (day) (year)
(c) Cemetery or crematory Salunda
Location Virginia.

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St.

OCT 21 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1947. 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947 to Oct. 18 1947. and that I last saw her alive on Oct. 18 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertensive Cardio-Vascular Renal Disease	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Manner of injury

23. Signature W. H. Howell M.D.
Address 601 E. Burrell Ave. Date signed 10/21/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered 56219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Abell Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh L. Shea

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 217-87-7655

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: W
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1887

8. AGE: Years 60 | Months 6 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Wisconsin (Town, county, and state)

10. Usual Occupation Insurance Agent

11. Industry or business

FATHER
12. Name Patrick Shea
13. Birthplace Mass.

MOTHER
14. Maiden Name Mary Mc Carthy
15. Birthplace Wisconsin

16 (a) Informant Mary Shea
(b) Address 3116 Abell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt Royal Ave

19 (a) OCT 21 1947 (b) (Registrar) Huntington Hall Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1947, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1947, to Oct 20 1947, and that I last saw him alive on Oct. 19 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchopneumonia	
Due to	
Other Conditions Auricular fibrillation	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Burkhart
Address Md. Deaf Hosp. Date signed 10/20/47 D

VS 150

X

G56220 B# #-91467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100 B

Registered No. G56220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 N. Woodington Rd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond A. Mc Dermott

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/15/47

8. AGE: Years — | Months — | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Joseph McDermott
13. Birthplace Maryland

MOTHER
14. Maiden Name Jean Atkinson
15. Birthplace Maryland

16 (a) Informant Mrs. Raymond Atkinson
(b) Address 621 N Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George L. Fahrwald
(b) Address 2101 Eutaw Place Ave.

19 (a) Date received 10-21-1947 (b) (Registrar) Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 19 47 at 1 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 19 47 to 10-21 19 47 and that I last saw h i M alive on 10-21 19 47

Immediate cause of death: Respiratory Failure — Duration
Due to:
Due to:
Other Conditions: Saddle Thrombus, Pulmonic Vein
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl Fisher M. D.
Address Bon Secours Hosp. Date signed 10-21-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

G56221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

207

Registered No. G56221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital. 3rd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Fawn St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Fullano

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fem'k	White	Married

6 (b) Name of husband or wife Genaro Fullano
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Sept. 30 1879

8. AGE: Years	Months	Days	If less than one day
68		19	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Fullano
13. Birthplace Italy

MOTHER
14. Maiden Name ? Fullano
15. Birthplace Italy.

16 (a) Informant Genaro Fullano
(b) Address 1009 Fawn St.

17 (a) Burial (b) Date thereof Oct. 23rd-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Baltimore Md

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St. Williamsport, Md.

19 (a) OCT 21 1947 (b) Huntingtown Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1947, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1947, to Oct. 19 1947, and that I last saw her alive on Oct. 19 1947.

Immediate cause of death	Duration
Ruptured abdominal aneurysm	5-10 mins
Due to Abdominal aneurysm	2 weeks plus
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert G. Johnson M. D.
Address Mercy Hospital Date signed 10-19-47

VS 150

G56222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G56222

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 353 Rosebank Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 353 Rosebank Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Olive Macy Shock

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Thomas A. W. Shock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1859

8. AGE: Years	Months	Days	If less than one day
88	--	6	hr. min.

9. Birthplace Boston, Mass. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm. D. Macy
13. Birthplace Nantucket, R. I.

MOTHER
14. Maiden Name Marilla Caverno
15. Birthplace N. H.

16 (a) Informant Mrs. Majori Marr Campbell
(b) Address 605 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1800 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1947 at 9 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1947 to Oct 20 1947.
and that I last saw [illegible] alive on Oct 9 1947.

Immediate cause of death Bronchial Pneumonia — Duration 4 days
Due to age
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. L. Kupfer M.D.
Address 1 W. Mulberry St. (Date signed) 10/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 056223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 N. Wolfe Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 N. Wolfe Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise W. Cunningham

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Christopher A. Cunn[illegible]
6 (c) If alive, give age [illegible] years
7. Birth date of deceased (mo., day, yr.) June 1, 1857
8. AGE: Years 90 | Months 4 | Days 18 | If less than one day ######## Hrs. ######## min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Michael Parr
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Bittner
15. Birthplace Germany

16 (a) Informant Miss. Mary T. Cunningham
(b) Address 1525 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.
18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue
19 (a) Oct 21 1947 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1947, at 5 17 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Oct 19 1947, and last saw her alive on Oct 19 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 hours
Due to: Hypertensive - Arteriosclerotic Cardiovascular Disease — Several years
Due to:
Other Conditions: None

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William H. Fiesting M.D.
Address 11 E. Chase St. Date signed 10/20/47

X

056224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 056224

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5815 Sefton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5815 Sefton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William D. Sachs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Pearl Sachs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1882

8. AGE: Years	Months	Days	If less than one day
64	11	27	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Theodore Sachs
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Young
15. Birthplace Germany

16 (a) Informant Mrs. Pearl Sachs
(b) Address 5815 Sefton Avenue 14

17 (a) Burial (b) Date thereof 10-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) Oct 21 1947 Washington Williams, M.D.
(Date received by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19th. 1947, 11:20AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov24th 1945 to Oct 19 1947 and that I last saw h. in alive on Oct. 19 1947

Immediate cause of death	Duration
Cardio-renal-vascular Disease	2yrs
Due to	
Due to	
Other Conditions Bronchial Asthma	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature J N Wilson M. D.
Address 617 N. 40th St Date 10/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 056225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Great Sanitarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2340 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alex Michaelson or Michasuk

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-16-9377

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Catherine Michaelson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19-1912

8. AGE: Years 35 | Months 4 3 | Days 1 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Stephan Michasuk
13. Birthplace Russia

MOTHER
14. Maiden Name Evgenia Jannie
15. Birthplace Russia

16 (a) Informant Mrs Catherine Michaelson
(b) Address 2340 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-22-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director John J. Greblunaskas Jr
(b) Address 0423 S. Paca St

19 Oct 21 1947 (Date rec'd by registrar) (b) Lustrig for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1947, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1947, to Oct. 17, 1947, and that I last saw him alive on Oct. 17 1947

Immediate cause of death

(a) Malarial Cachexia — Duration: 4 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Duncan Tapp M.D.
Address Date signed 10/20/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

T# G56226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G56226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2587 EDMONDSON AVE.
(c) Hospital or institution: ********** 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 2587 EDMONDSON AVE. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No) If yes, name country

3 (a) FULL NAME BESSIE L. EAGLESTON

3 (b) If veteran, name war **********

3 (c) Social Security Account No. 218-22-6320

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: George E.

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) AUG. 16-1897

8. AGE: Years 50 | Months 2 | Days 9 | If less than one day: **********hr. **********min.

9. Birthplace: BALTIMORE MARYLAND (Town, county, and state)

10. Usual Occupation: CLERK

11. Industry or business: BALTIMORE NEWS POST

FATHER
12. Name: CHARLES S.GILBERT
13. Birthplace: BALTIMORE MARYLAND

MOTHER
14. Maiden Name: BESSIE S.BALDWIN
15. Birthplace: BALTIMORE MARYLAND

16 (a) Informant: GEORGE I.EAGLESTON
(b) Address: 2587 EDMONDSON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 22/47 (month) (day) (year)
(c) Cemetery or crematory GREEN MOUNT CEM.
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE...17.

19 (a) OCT 21 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 19/47 19.... at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1947 to Oct. 19 1947 and that I last saw her alive on Oct. 19 1947

Immediate cause of death	Duration
Myocardial Degeneration	5 days
Due to Bronchial Asthma	4 yrs.
Due to Lobar Pneumonia	11 days.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward E. Bogorad M. D.
Address 1905 W. Baltimore Date signed

VS 150

G56227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56227 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Cathedral Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert K. Adams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 14, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 21 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1947, at 1 25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/24/47

VS 191

C56228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. C56228

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) abt 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2057 Kennedy Av.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Estelle Murphy

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband ~~or wife~~: John Thomas Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-22-90

8. AGE: Years 57 | Months 7 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: None

FATHER
12. Name: ? Chance
13. Birthplace: Maryland

MOTHER
14. Maiden Name: ? Acker
15. Birthplace: Maryland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Edmondson Ave., City

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Ave., City

19 (a) 21 1947 (Date rec'd by registrar) (b) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1947 at 2.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1947 to Oct 19 1947 and that I last saw her alive on Oct 19 1947

Immediate cause of death	Duration
Bleeding esophageal varices	4 days
Due to Hepatic cirrhosis	4yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John G. Lamb M.D.
Address Johns Hopkins Hosp Date signed Oct 24 1947

VS 150

56229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

Registered No. 56229

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospita 21 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613- Scott Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KAZIMER MACKEN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rose Mary Macken
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Apr. 16, 1885

8. AGE: Years 62 | Months 6 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace: Yugoslavia (Town, county, and state)
10. Usual Occupation: Trackman
11. Industry or business: B & O R. R.

FATHER
12. Name: Michael Macken
13. Birthplace: Yugoslavia

MOTHER
14. Maiden Name: Anna -
15. Birthplace: Yugoslavia

16 (a) Informant: Mrs. Anna Livingston
(b) Address: 763 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/47 (month) (day) (year)
(c) Cemetery or crematory: Meadowridge Cem.
Location: Howard County, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) Oct 21 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20; 1947, at 3 p. M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured skull
Laceration of brain
Fractured right femur
Due to: Fractured left humerus.
Fractured pelvis
crushed chest
Other Conditions: Lacerations of spleen, Kidney, on heart, and lung.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 21/1

(a) Date of injury 10-20-47 2.30 p. M.
(b) Where did injury occur? B.&O R. R. Warner St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury: Pedestrian-struck by train

23. Signature: George A. Merrill Medical Examiner. M.D.
Date signed 10-21-47

X

G56230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Palm Beach, Lakeworth
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 N. H. Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LESLIE CURTIS ALDRICH

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?, 1874

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Meridale Co. New York
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Charles Wesley

13. Birthplace Tuckerown

MOTHER 14. Maiden Name Anna Jane Dawson

15. Birthplace Tuckerown

16 (a) Informant Frank Ellwood Aldrich

(b) Address Route-1-Box 409 Dover Fla.

17 (a) Burial (b) Date thereof Oct 22 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Fairmount

Location Hayards-Trappe Road

18 (a) Funeral director Ellsworth Armacost

(b) Address 3911 Liberty Heights Ave.

19 (a) OCT 21 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1947, at 8.10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSHION OF DEATH. Fractured Cervical Vertebrae
Multiple fractures
Ruptured liver
Due to Internal hemorrhage

Other Conditions Lacerations, abrasions & bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: Howard Co.

(a) Date of injury 10-17-47 7.30 P. M.

(b) Where did injury occur? Route #1, Elkridge, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian-struck by auto

23. Signature Howard J. Madeira M.D.
Medical Examiner.

Date signed 10-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1226

Registered No. 056231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Pennington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth McNally

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Husband

6 (b) Name of husband or ~~wife~~ Wm. McNally

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1884

8. AGE: Years	Months	Days	If less than one day
63	4	28	hr. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation Home-maker

11. Industry or business

FATHER
12. Name James D. Muir
13. Birthplace Scotland

MOTHER
14. Maiden Name Rosy Ann Shields
15. Birthplace Scotland

16 (a) Informant Mr Toelle
(b) Address 3814 Pennington Ave

17 (a) Burial (b) Date thereof Oct 24-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem.
Location Cor Potapsco Highway Brooklyn

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St - 25

19 (a) OCT 21 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1947, at 1:37 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Oct. 1947, to 21 Oct. 1947, and that I last saw her alive on 20 Oct. 1947

Immediate cause of death	Duration
Bronchopneumonia, acute	
Due to Massive adhesions causing intest. obstruction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12 Oct. 1947

Major findings of operation: Massive adhesions; chronic peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. T. B. Horgan M. D.

Address Md. Gen. Hosp. Date signed 21 Oct 47

G56232

a.c # 7-92257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G56232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town, give name of county)
(d) Street No. 22 [illegible] U. Hospital (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	negro	infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-17-47

8. AGE: Years	Months	Days	If less than one day
			21 hr. 19 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Newman
13. Birthplace Virginia

MOTHER
14. Maiden Name Selma Elizabeth Roberts
15. Birthplace Maryland

16 (a) Informant Selma Elizabeth Roberts
(b) Address Baltimore, Maryland

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 21 1947

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 22 1947 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18-1947, at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17-1947, to 10-18-1947, and that I last saw her alive on 10-18-1947.

Immediate cause of death	Duration
prematurity	
Due to Caesarean section on account pre-eclamptic toxemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles A Mauron M. D.
Address University Hosp. Date signed 10-18-47

G56233 BC 3 91630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G56233

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution:
The Johns Hopkins Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 936 S. Hanover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/47

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Jesse Wise
13. Birthplace Maryland

MOTHER
14. Maiden Name Sadie Bailey
15. Birthplace South Carolina

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo OCT 21 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 22 1947 (Date rec'd by registrar) Hyslop Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1947, at 1.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1947 to Oct 17 1947, and that I last saw him alive on Oct 17 1947.

Immediate cause of death	Duration
Prematurity Atelectasis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B C Williams M. D.
Address Johns Hopkins Hospital Date signed 10-18-47

G56234 B.C. 5-1972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 159

G56234 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-19-47

8. AGE: Years — | Months — | Days — | If less than one day 2 hr. 30 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name Gloria Miller

MOTHER 15. Birthplace Md

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical Schoo OCT 21, 1947

18 (a) Funeral director Commissioner of Health

(b) Address

OCT 22 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19-47 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on 10-19-1947.

Immediate cause of death	Duration
ASPHYXIA NEONATORUM	
Due to ATELECTASIS	
Due to PREMATURITY - WT. 4 LBS	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Spencer M.D.

Address Johns Hopkins Hosp. Date signed Oct 20th 1947

Burnett Lane

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Russell St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 21, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 22 1947 (Date rec'd by registrar) (By) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1947, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rogers M.D. Medical Examiner.
Date signed 11-9-47

VS 181

G56236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56236 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309- W Fremont ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309- W. Fremont ave N. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred DENNIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 21, 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) OCT 22 1947 (Date rec'd by Registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947, at 8:59 a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 10/6/47

G56237 8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓186a

G56237 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 St. Matthews St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Greenbury Miller

3 (b) If veteran, name war .
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Undetermined
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 21 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 22 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH October 10, 1947 at 8 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Arteriosclerotic cardiovascular-renal disease.

Fractured ribs.

Other Conditions 1

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 10/7/47 1230 P.M.
(b) Where did injury occur? 1226 St. Matthews St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell to floor

23. Signature George G. Merrill M.D. (Medical Examiner)
Date signed 10/11/47

VS 151

G56238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G56238 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Ha A

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 N. MADEIRA
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN TRACY, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-1881

8. AGE: Years 65 | Months 8 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John T. Tracy
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Balto.

16 (a) Informant Frances Tracy
(b) Address 215 N. Madeira St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

OCT 22 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/47 19 , at 3:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy / Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 10/20/47

G56239 3791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G56239 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3021 Chelsea Ter
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LEON HENESON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife. Gertrude Heneson
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug. 15. 1883

8. AGE: Years	Months	Days	If less than one day
64	2	7	....hr. ....min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Heneson
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie ?
15. Birthplace Russia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-47 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Rawa Inc
(b) Address 2160 Eutaw Place

19 (a) OCT 22 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1947 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1947, to 10/22 1947, and that I last saw h alive on 10/22 1947.

Immediate cause of death: Carcinoma of Lung, Left — Duration: 5 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation April 1947
Major findings of operation: Inoperable Carcinoma
of autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. McCoy M.D.
Address Johns Hopkins Hosp. Baltimore, Md. Date signed 10/22/47

656240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

656240 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1829 N. Milton Ave.
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICKA M. LUBER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife John G. Luber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1872

8. AGE: Years 74 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Wittmer
13. Birthplace Germany

MOTHER
14. Maiden Name Eliz.
15. Birthplace Germany

16 (a) Informant Mr. Oliver P. Luber
(b) Address 1829 N. Milton Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/24/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Lemmon Funeral Home
(b) Address 7401 Belair Rd.

19 (a) 10-29-1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150 A R 1A1A

MEDICAL CERTIFICATION P

20. DATE OF DEATH Oct. 20th 1947, at 4:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1947 to Oct 20 1947, and that I last saw h[illegible] alive on Oct 20 1947

	Duration
Immediate cause of death: Cardiovascular	4 days
Due to: Hypertension	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Fred Runyon M.D.
Address 600 Cathedral St Date Oct 29 1947

G56241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 52B

Registered No. G56241

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6415 Brook Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6415 Brook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HULDA A. GREENBECK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John E. Greenbeck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13th, 1877

8. AGE: Years	Months	Days	If less than one day
69	11	7	hr. min.

9. Birthplace Denmark (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Blom
13. Birthplace

MOTHER
14. Maiden Name unk
15. Birthplace

16 (a) Informant Mr. John E. Greenbeck
(b) Address 6415 Brook Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/23/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lazarah Funeral Home
(b) Address 7401 Belair Rd.

OCT 22 1947 (Date rec'd by registrar) (b) Washington Nilliams M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20th 1947, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1946, to 10-20 1947, and that I last saw h[illegible] alive on 10-15-1947

Immediate cause of death	Duration
Carcinoma Urinary Bladder	18 Months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Feb. 1944
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4508 Harford Rd Date signed 10-21-47

G56242 BC# G-85279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 114E

G56242
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1034- N. Luzerne Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1034- N.Luzerne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS HASLBECK, Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1947

8. AGE: Years	Months	Days	If less than one day
	3 2	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Francis W Haslbeck
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Sally Cimino
15. Birthplace Baltimore, Md

16 (a) Informant Francis W Haslbeck, Sr
(b) Address 1034 N Luzerne Avenue

17 (a) Burial (b) Date thereof 10/23/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location Belair Rd Baltimore, Md

18 (a) Funeral director Charles E Schimunek
(b) Address 2601-3-5 E Madison Street

19 OCT 22 1947 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1947, at 8.15 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia, from aspiration of mucus and obstruction of bronchi

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 10-21-47

G56243

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G56243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (23)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2645 Dulany St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret E Widmyer (MARGARET E. WIDMYER)

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-6443

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Richard J.

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 10/15/1898

8. AGE: Years 49 | Months -- | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Sausage Maker

11. Industry or business Louis Sands Co.

FATHER 12. Name John WELSCH

13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen DONAHUE

15. Birthplace Ireland

16 (a) Informant MR. RICHARD J. WIDMYER

(b) Address 2645 Dulany Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore Maryland

18 (a) Funeral director F.B. WIPPERT & SON

(b) Address 1300 EUTAW PLACE...17

19 (a) OCT 22 1947 (Date rec'd by Registrar) (b) Transit for Williamsport Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1947 at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1947 to Oct 21 1947 and that I last saw h-er alive on Oct 21 1947.

	Duration
Immediate cause of death Pulmonary edema	
Due to Generalized sepsis	
Due to Cachexia due to Carcinoma of colon	
Other Conditions Nodera	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Calvin B Kearns M. D.

Address Univ. Hosp. Balto, Md Date signed 10-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

656244 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 N. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 627 N. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mabel B. Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robert B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1872

8. AGE: Years	Months	Days	If less than one day
65	5	9	hr. min.

9. Birthplace Wilmington, Del. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William L. Kelly
13. Birthplace Maryland

MOTHER
14. Maiden Name Wilhelmena Sutter
15. Birthplace Smyrna, Del.

16 (a) Informant Miss Mabel A. Scott
(b) Address 627 N. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Chas. A. Hafler
(b) Address 1691 Druid Hill Ave.

Oct 22 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19, 1947, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1947 to Oct 19 1947 and that I last saw h[illegible] alive on Oct 19 1947.

Immediate cause of death	Duration
(a) Congestive Heart failure	1 day
Due to (b) Hypertension Heart disease	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Oct 20 1947

656245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E

Registered No. G56245

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave
(c) Hospital or institution: West Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2565 W Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward John Burns

3 (b) If veteran, name war	3 (c) Social Security Account No. 219-05-4504

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mary E Burns
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Dec 2-1904

8. AGE: Years	Months	Days	If less than one day
42	10	18	hr. min.

9. Birthplace Baltimore Co (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business National casket Co

FATHER
12. Name George Burns
13. Birthplace Balto Co

MOTHER
14. Maiden Name Louise Wilson
15. Birthplace Balto Co

16 (a) Informant Mary E Burns
(b) Address 2805 W Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23-47 (month) (day) (year)
(c) Cemetery or crematory Poplar Grove Cem
Location Cockeysville, Md

18 (a) Funeral director Chas P Doell
(b) Address 2427 E Monument Ave

19 (a) Oct 22 1947 (Date rec'd by registrar) (b) Lillian Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1947, at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1947 to 10/20 1947, and that I last saw h[illegible] alive on 10/20 19 47

Immediate cause of death	Duration
Cardio-respiratory failure.	
Due to Aortic insufficiency	
Due to Luetic heart disease	
Other Conditions Emphysema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Tucker, MD M. D.
Address West Baltimore Dental Oct 20, 47

VS 150

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1860

G56246 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Longwood & Raynor Ave.
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Mt. Holly St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie E. Walker (CARRIE E. WALKER)

3 (b) If veteran, name war	3 (c) Social Security Account No.
**********	*******

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife John Walker
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 11 - 11 - 1863

8. AGE: Years	Months	Days	If less than one day
83	11 10	8	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Housewife at Home
11. Industry or business

FATHER
12. Name Frederick Deets
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah North
15. Birthplace Maryland

16 (a) Informant Mr Harry F. Herbert
(b) Address 504 Mt. Holly Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Maryland

18 (a) Funeral director F.B. WIPPERT & SON..
(b) Address 1300 EUTAW PLACE...

19 (a) 10-22-1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Oct 1947, at 7 1/2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Oct 1947 to 19 Oct 1947 and that I last saw her alive on 19 Oct 1947.

Immediate cause of death	Duration
Probable Cerebro-vascular accident	
Due to Hypertension & Cerebro-vascular involvement	
Due to Arteriosclerosis	
Other Conditions Basilar pneumonia Fractured left hip	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Basilar pneumonia
of autopsy: Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/7
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Oct. 31, 1947 2:30 A.M.
(c) Where did injury occur? 304 Mt. Holly St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? NO
(e) Means of injury: Fell out of bed striking head on floor
23. Signature C. J. Lubinski M.D.
Address 1100 E. Monument Date signed 10/24/47

VS 150 C. J. Lubinski M.D. 1100 E. Monument

X

G56247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No. G56247

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 137 N. Potomac St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Schuerhais

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Lawrence W. Schuerhais
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1890

8. AGE: Years	Months	Days	If less than one day
57	2	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Henry Ziegler
13. Birthplace Maryland.

MOTHER
14. Maiden Name Rena Stronck.
15. Birthplace Maryland.

16 (a) Informant Lawrence W. Schuerhais
(b) Address 137 N. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23, 1947 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location Edgemont St

18 (a) Funeral director John G. Moran
(b) Address 3950 E Balt. St

19 Oct 22 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

V S 190^A 1A1A

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947 to Oct 20 1947, and that I last saw h[er] alive on Oct 19 1947.

Immediate cause of death	Duration
(a) Carcinoma Breast (Ca)	4 Mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 1947
Major findings of operation: Ca.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J F A Strouss M. D.
Address 2818 Hartford Rd Date signed 10-21-47

G56218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56218

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Shadyside
(If outside city or town limits, write RURAL and give town)
(d) Street No. ....
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ....

3 (a) FULL NAME Albert Washington

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	col	Married

6 (b) Name of husband or wife Minnie Matthews Washington
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) ? 1898

8. AGE: Years	Months	Days	If less than one day
49	—	—	....hr. ....min.

9. Birthplace Shadyside, Md.
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Merchant Seaman

FATHER
12. Name George Washington
13. Birthplace Va.

MOTHER
14. Maiden Name Willie Ann Holland
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24/47 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Shadyside Md
18 (a) Funeral director J. B. Johnson
(b) Address Annapolis, Md.
19 OCT 22 1947 (Date rec'd by Registrar) (b) Registrar's signature ....

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1947, at 12:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1947 to Oct. 21 1947, that I last saw him alive on Oct. 21 1947.

	Duration
Immediate cause of death Hypertensive cardio-vascular disease	Three yrs
Due to Cardiac insufficiency	
Due to Uremia	
Other Conditions Hypertensive encephalopathy	

(Include pregnancy within 3 months of death)
Date of operation ....
Major findings of operation ....
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ....
(b) Date of occurrence .... at .... M
(c) Where did injury occur? .... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? .... While at work? ....
(Specify type of place)
(e) Means of injury ....
23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon 10/21/47
Address Clinical Director Date signed

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G56249 **CERTIFICATE OF DEATH** 1131a Registered No. G56249

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 BURGUNDY ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 21
(e) Length of stay in Baltimore (yrs., mos., or days): LIFETIME

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Burgundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CAROLINA J. REY

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	WHT	WIDOW

6 (b) Name of husband or wife DECEASED.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 17 1887

8. AGE: Years	Months	Days	If less than one day
60	2	4	hr. min.

9. Birthplace BALTO (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER — 12. Name	HENRY JACOB
FATHER — 13. Birthplace	GERMANY
MOTHER — 14. Maiden Name	MARIA BERCH.
MOTHER — 15. Birthplace	GERMANY

16 (a) Informant HENRY REY
(b) Address 800 BURGUNDY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-24-47 (month) (day) (year)
(c) Cemetery or crematory LORRAINE PK
Location DICKEYVILLE

18 (a) Funeral director GEO. H. LEIMBACH
(b) Address 528 N. LYNDHURST ST

(Date rec'd by registrar) (b) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1947, at 11 30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1946 to 10-21 1947. and that I last saw h[er] alive on 10-21 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	1 da
Due to Arterio Sclerotic Renal Disease	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph L. Lankenau M. D.
Address 679 Washington Blvd Date signed 10/24/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

G56250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G56250

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Harmer Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ESTHER Esther Kopanski (Graber)

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Frank

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 7-31-13

8. AGE: Years 34 | Months 2 | Days 20 | If less than one day ___ hr. ___ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at Home

MOTHER FATHER
12. Name Edward Hodges
13. Birthplace Md.
14. Maiden Name Martha Cornelius
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24 '47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Baltimore Memorial Cemetery
Location 5600 Frederick Rd

18 (a) Funeral director Calvert W. Cornelius Sons
(b) Address 224 E. Eager St.

19 (a) OCT 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-47 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1947 to 10-21 1947 and that I last saw her alive on 10-21 1947

Immediate cause of death: Cardiac Failure — Duration 2 Mo.

Due to: Rheumatic Heart Disease — 20 yrs.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Y. Leonard
Address Johns Hopkins Hosp. Date signed 21 Oct 1947

G56251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G56251 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 Colorado Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Colorado Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Eugene Scanlin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Minnie V. Scanlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28-1878

8. AGE: Years 69 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Special Agent - Retired
11. Industry or business Chesapeake Steamship Co.

FATHER
12. Name Benjamin Scanlin
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret C. Kelly
15. Birthplace Maryland

16 (a) Informant Edwin E. Scanlin
(b) Address 624 Colorado Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3634 Edmondson Ave. Catonsville, Md.

19 (a) OCT 22 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20- 1947, at 9.05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Oct 1947, and that I last saw h. alive on 20th Oct 1947

Immediate cause of death: Carcinoma of Colon — Duration —
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William L. Helfrich
Address 5006 Roland Ave Date signed Oct 21, 47

V S 150

Balto-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

G56252

BALTIMORE CITY HEALTH DEPARTMENT G56252

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3211 Bayonne Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Bayonne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES CRAWFORD CANNON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M.

6 (b) Name of husband or wife Florence B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30-1877

8. AGE: Years	Months	Days	If less than one day
69	9	20	hr. min.

9. Birthplace Trappe - Md.
(Town, county, and state)
10. Usual Occupation B. & O. R.R.
11. Industry or business Engineer

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Florence B. Cannon
(b) Address 3211 Bayonne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

OCT 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/47 19 , at 5:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 10/21/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56253 BALTIMORE CITY HEALTH DEPARTMENT G56253

CERTIFICATE OF DEATH (X) 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton ave.
(c) Hospital or institution: St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town Baltimore. Laurel (If outside city or town limits, write RURAL and give town)
(d) Street No. Laurel Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Jane Clampet

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	M.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-22-1875

8. AGE: Years	Months	Days	If less than one day
72	-	-	hr. min.

9. Birthplace Winston Salem - N. C. (Town, county, and state)
10. Usual Occupation House wife.
11. Industry or business

FATHER
12. Name - Dec'd Bowers.
13. Birthplace N. C.

MOTHER
14. Maiden Name Sarah.
15. Birthplace N.C. Winston Salem

16 (a) Informant Laurel Md.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-47 (month) (day) (year)
(c) Cemetery or crematory Lebanon Cemetery
Location Statesville N. C.
18 (a) Funeral director W. H. Grayburn Co
(b) Address 508 Cleveland Ave
19 (a) Rundale (b) Filed Nov 1 1947 (Date rec'd by registrar) Williams Registrar

OCT 22 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22- 1947, at 2 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Oct 1947 to 22 Oct 1947 and that I last saw h[illegible] alive on 21 Oct 1947

Immediate cause of death	Duration
Cerebro-Vascular Hemorrhage	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. E. Hamill M.D. M. D.
Address Agnes Hosp Date signed 22 Oct 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 83a

G56254 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Pinehurst
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6312 Blackburn Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LeRoy H. CORDRAY

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 217-14-1114

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Elnora W. Cordray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 26, 1895

8. AGE: Years	Months	Days	If less than one day
52	4	15	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Bank Clerk

11. Industry or business: First National Bank

FATHER
12. Name: Gordon Cordray
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Margaret Berry
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Elnora W. Cordray
(b) Address: 6312 Blackburn Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) 1947 (b) Received by registrar: Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1947, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1947 to Oct. 21 1947 and that I last saw h/M alive on Oct. 21 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John Gordon Mosser Jr. M.D.
Address 1111 E. Mont. Date signed 10-21-47

Margaret Fox

56255 Brett Jester Jo. 91548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 56255

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1000 Hyltenware

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 2

(e) Length of stay in Baltimore (~~yrs., mos., or~~ days) x

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1943 Edmondson Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Ewig.

3 (b) If veteran, name war

3 (c) Social Security Account No. no

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife no

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/11/47

8. AGE: Years | Months | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name William Ewig

FATHER 13. Birthplace

MOTHER 14. Maiden Name Mary Jeanne Deck

MOTHER 15. Birthplace Md.

16 (a) Informant Mrs Eugene Deck

(b) Address 1943 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14-47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem

Location

18 (a) Funeral director Charles P Powell

(b) Address 1427 Edmondson Ave

19 (Date rec'd by Registrar) (by) for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..... to 19....., and that I last saw h..... alive on 19.....

Immediate cause of death Respiratory failure — Duration

Due to prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles A. Bowers, Jr. M. D.

Address St. Agnes Hospital Date signed 10/14/47

G56256

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G56256 95c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond SEABREASE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Agnes Seabrease
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7th 1891

8. AGE: Years	Months	Days	If less than one day
56	11	14	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Sydenham Hospital

FATHER
12. Name Richard F. Seabreaser
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Wise
15. Birthplace Md.

16 (a) Informant Agnes Seabrease (Wife)
(b) Address 839 Woodward St.

17 (a) Burial (b) Date thereof 10/23/47 (month) (day) (year)
(Burial, ~~cremation, or removal~~)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date rec'd by registrar (b) Registrar

OCT 22

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1947, at 12 50 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart
Acute pulmonary edema.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 10/21/47

10/21/47 X

G56257

G56257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 831 W. Barre st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 W. Barre st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES LUDWITZKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Mary Ludwitzke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Huckster

11. Industry or business Own

FATHER 12. Name Frank Ludwitzke

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Wilhelmina Drehr

MOTHER 15. Birthplace Germany

16 (a) Informant Mary Ludwitzke

(b) Address 58 E. Heath st.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/24/47 (month) (day) (year)

(c) Cemetery or crematory Greenlawn

Location Irvington Balto Co Md

18 (a) Funeral director Wilson Co Inc

(b) Address 1214 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21- 1947 at 10:45 AM

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 10/21/47

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1125a

~~G56258~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dulaney & Rayner Ave
(c) Hospital or institution: West Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 N Culver St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia Roy (Lydia Jane Roy)

3 (b) If veteran, name war NP

3 (c) Social Security Account No. 212-10-6297

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John Ross Roy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1872

8. AGE: Years 75 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Westminster Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant John L Roy Jr
(b) Address 226 N Culver St

17 (a) Burial (burial, cremation, or removal) **(b) Date thereof** 10 24 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md

18 (a) Funeral director Wilhelm & Son
(b) Address 1214 Pennsylvania Ave

19 (a) (Date rec'd by registrar) Registrar

OCT 28 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-47 19 , at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1947 to 10-21 1947, and that I last saw her alive on 10-21 1947.

	Duration
Immediate cause of death Massive Bleeding	
Secondary Hypoprothrombinemia	
Due to Liver Necrosis	
Due to Thyrotoxicosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Not Done
of autopsy: Some

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Leshansky M. D.
Address West Balto Genl Hosp **Date signed** 10-22-47

X

G56259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56259 Registered No.

95c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green Sts

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Ellicott City Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. Westchester Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MARY KAVANAUGH

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1871

8. AGE: Years	Months	Days	If less than one day
76	1	13	hr. min.

9. Birthplace Ellicott City, Balto. Co. Md. (Town, county, and state)

10. Usual Occupation School teacher

11. Industry or business Public school

FATHER 12. Name Denis Kavanaugh

13. Birthplace Co. Mayo, Ireland

MOTHER 14. Maiden Name B. Elizabeth Martin

15. Birthplace Co. Mayo Ireland

16 (a) Informant Mrs. Lillian Hann

(b) Address Ellicott City Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24 1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location Old Frederick Rd Balto. Md.

18 (a) Funeral director Easton Sons

(b) Address Ellicott City, Md.

19 (a) Oct 2 1947 (Date received by registrar) (b) Huntington Williams Registrar

OCT 2

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1947, at 5:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1947, to Oct 21 1947, and that I last saw h. alive on Oct 20 1947

Immediate cause of death	Duration
respiratory failure	
Due to Cardiac decompensation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert C. Dunnall Jr MD M. D.

Address Univ. Hosp. Date signed Oct 21

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 656260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Colvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Glenarm
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN GEORGE WEBER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Olive E. Weber
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 6, 1886
8. AGE: Years 61 | Months 4 | Days 16 | If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business American Oil Co

FATHER
12. Name John G. Weber
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary M. Stripling
15. Birthplace Maryland

16 (a) Informant Olive E. Weber
(b) Address Glenarm, Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 25 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave
18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road
19 (Date rec'd by registrar) OCT 23 1947 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1947 at 2:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1947 to Oct 22 1947. and that I last saw h[illegible] alive on Oct 22 1947.

Immediate cause of death	Duration
Increased intracranial pressure	8 hrs
Due to Carcinoma, metastatic, st. motor cortex, cerebrum	3 months
Due to	[illegible] months
Other Conditions Tumor, bronchus	

(Include pregnancy within 3 months of death)

Date of operation Oct 21 1947
Major findings of operation Metastatic carcinoma, st. cerebrum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clinton P. Brown M.D.
Address Union Memorial Hosp. Date signed Oct 22 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

C56261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C56261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4223 Belmar ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Vambaugh. Sr.
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-03-2795

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widower
6 (b) Name of husband or wife: Leonie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1890

8. AGE: Years 57 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Pennsylvania. (Town, county, and state)
10. Usual Occupation Shoeworker
11. Industry or business Shoe Factory (Finish)

FATHER
12. Name Albert Vambaugh
13. Birthplace Penna

MOTHER
14. Maiden Name Anna Schultz
15. Birthplace Penna.

16 (a) Informant Mrs. Beulah Arndt
(b) Address 4223 Belmar ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 24 47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Emory H. Blight, Jr.
(b) Address 4914 Belair Road

19 (a) OCT 23 1947 (Date rec'd by registrar) (b) Huntingtn for Williams Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21/47 19 at 3:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19/47 19 to 10/21/47, and that I last saw h[illegible] alive on 10/21/47.

Immediate cause of death: Cerebral Hemorrhage, Due to Hemiplegia Left, Due to Arterio-Sclerosis, General, Due to Arterio-Sclerotic Heart Disease

Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph D'Antonio
Address Church Home & Hosp. Date signed 10/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. 056262

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 west 25th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Harrison Cornelius

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Sarah Cornelius
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/18/870

8. AGE: Years	Months	Days	If less than one day
77	8	4	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Peter L. Cornelius
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Amanda Mullen
15. Birthplace Pennsylvania

16 (a) Informant Mrs Sarah A. Cornelius
(b) Address 130 W. 25th St. City.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/24/47 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Alverton Pa.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

19 OCT 23 1947 (Date rec'd by registrar) (b) Funeral director's Registration No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1947, at 6:22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from September 25 1947 to October 22 1947, and that I last saw h[illegible] alive on oct 22 1947.

Immediate cause of death Coronary Thrombosis — Duration 36 hours
Due to Arteria Sclerotic heart disease — 7 years +
Due to
Other Conditions Severe Prostatic hypertrophy — 1 year +
(Include pregnancy within 3 months of death)
Date of operation 10-3-47
Major findings of operation: benign Prostatic hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature L. Richard Bowers M. D.
Address Union Memorial Hosp. Date signed 10/23/47

G56263 Blk # 91540 — BALTIMORE CITY HEALTH DEPARTMENT — G56263 Registered No.

CERTIFICATE OF DEATH 161a

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 Division St.
(c) Hospital or institution: President Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Mc Henry Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Baby Matthews Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 2 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name James Henry Matthews
13. Birthplace Baltimore Md.

MOTHER — 14. Maiden Name Clarissa Katherine Willis
15. Birthplace Fayetteville N. Virginia

16 (a) Informant Clarissa Matthews
(b) Address 1902 Mc Henry Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 22 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14- 1947, at 11: A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1947 to Oct. 14 1947 and that I last saw him alive on Oct. 14 1947.

Immediate cause of death	Duration
Due to Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry E. Watson, M.D.
Address 2340 Maryland Date signed 10-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656264 Blk 73-9131 8 BALTIMORE CITY HEALTH DEPARTMENT 159 Registered No. 656264

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto 9
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1507 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-13-47

8. AGE: Years | Months | Days | If less than one day: 17 hr. — min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden Name Mary
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical Schoo OCT 15 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 23 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13-1947, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13-1947, to 10-13-1947 and that I last saw h[illegible] alive on 10-13-1947.

Immediate cause of death ASPHYXIA NEONATORUM — Duration
Due to PREMATURITY
Due to
Other Conditions? INTRACRANIAL HEMORRHAGE
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Spencer M.D.
Address Johns Hopkins Hospital Date signed Oct 14 1947

Harriet Lane Home

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B62
4-91182

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G56265 ✓159 Registered No. G56265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison and Linden
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3343 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Butschky Butschkey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/47

8. AGE: Years | Months | Days ✓ | If less than one day ... hr. ... min.

9. Birthplace Md. Gen. Hosp.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Henry Butschky
13. Birthplace Balto Md

MOTHER
14. Maiden Name Myrtle Johnson
15. Birthplace Bkrs. Md

16 (a) Informant George H. Butschky
(b) Address 3343 Belair Rd

17 (a) ... (b) Date thereof ...
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 22 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) ... (b) ...
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/47 19... at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19/47 19... to 10/20 19..., and that I last saw h[illegible] alive on 10/20 19 47

Immediate cause of death Prematurity 3 days

	Duration
Due to	
Due to	
Other Conditions Partial atelectasis	

(Include pregnancy within 3 months of death)
Date of operation 10/19/47
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas C. Wilson M. D.
Address Md. Gen. Hosp. Date signed 10/20/47

VS 150

#56266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1112

Registered #56266

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3241 Belmont Avenue
(c) Hospital or institution:
Home 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3241 Belmont Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Christine Fox

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Albert E. Fox
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July-21-1887

8. AGE: Years	Months	Days	If less than one day
60	3	0	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Oscar Gesell
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha ? ?
15. Birthplace Germany

16 (a) Informant Mr. Albert E. Fox (husband)
(b) Address 3241 Belmont Avenue, City

17 (a) Entombment (b) Date thereof Oct-23-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Maryland

18 (a) Funeral director Stewart & Bowen Company
(b) Address 105 W. North Avenue, City #1

19 (a) OCT 23 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1947; at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1947 to Oct. 21, 1947 and that I last saw her alive on Oct. 21 1947

Immediate cause of death	Duration
Bronchial asthma with pulmonary failure	One day
Due to Bronchial asthma	8 years
Due to Chronic respiratory infection (non-tuberculous) from Dec, 1946	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice E. Shannon M. D.
Address 3300 W. North Ave. Date signed 10/22/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G56267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G56267 Registered No. 41583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts
(c) Hospital or institution:
Union Memorial Hosp 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Taplow Rd. (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Schleunes (ALFRED SCHLEUNES)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel Schleunes

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1872

8. AGE: Years 74 | Months 10 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore MD. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Francis Schleunes
13. Birthplace Germany

MOTHER
14. Maiden Name Matilda Kunzman
15. Birthplace Phila. Pa.

16 (a) Informant Mrs. Schleunes (wife)
(b) Address 304 Taplow Rd. Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Stuart Morgan & Co
(b) Address 1084 W North Ave.

19 (a) OCT 23 1947 (Date rec'd by registrar) (b) Huntington Mill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1947, at 4:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1947, to Oct. 21 1947, and that I last saw h.c.m. alive on Oct. 21 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchopneumonia	
Due to	
Other Conditions Arteriosclerotic C.V. disease, Hypertension of colon	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: [redacted]

of autopsy: U.S.T. Dr. W.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Hagan Jr. M.D. M. D.

Address [redacted] Date signed Oct 23 47

Union Mem. Hosp.

VS 150

107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C56268

CMK-87199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1931)

Registered No. C56268

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Years
(e) Length of stay in Baltimore (yrs., mos., or days) 43 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Alcorn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Anna (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1-1861

8. AGE: Years	Months	Days	If less than one day
86	7	17	hr. min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Alcorn
13. Birthplace ?

MOTHER
14. Maiden Name Anna ?
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Pk.
Location Howard Co., Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) OCT 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH October 18 1947, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1944, to Oct. 18 1947, and that I last saw h. alive on Oct. 18 1947.

Immediate cause of death Myocardiosclerosis & Arteriosclerotic C-V Disease — Duration

Due to

Due to

Other Conditions Hypostasis Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto City Hosp. Date signed 10-24-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G56269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 South Street
(c) Hospital or institution: (Safe Deposit & Trust Co.)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Earle Hooper

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1901

8. AGE: Years	Months	Days	If less than one day
46 4 1	4	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Safe Deposit & Trust Co

FATHER
12. Name Charles A. Hooper
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary M. Popp
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary M. Hooper
(b) Address 117 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1947, at 11 52 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 10-22-47

VS 181

656270 BC# 690467

GM. 114186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 159

Registered No. 656270

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 N. Caroline ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johnson Baby Girl (Sylvia)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30 -1947

8. AGE: Years	Months	Days	If less than one day
		14	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas
13. Birthplace ?

MOTHER
14. Maiden Name Sylvia
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 10-22-47
(Burial, cremation, or removal) 9am (month) (day) (year)
(c) Cemetery or crematory B. C. Hosp.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 OCT 22 1947 (b) Huntington for Williams, Mgr
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 - 1947, 6.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 - 30 - 1947 to Oct. 14 -1947 and that I last saw her alive on Oct. 14- 1947

Immediate cause of death	Duration
Meningitis (Pneumococci)	3 days
Due to	
Due to	
Other Conditions Prematurity	14 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Meaingitis, Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lucian P. Griffin M. D.
Address Balt. City Hosp. Date signed 21 Oct 1947

056271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered 056271

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3213 Stafford St.

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3213 Stafford St.
(If rural give location)

(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Leitzman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-03-6968

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Katherine

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1887

8. AGE: Years	Months	Days	If less than one day
59	10	1	..... hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name Otto Leitzman
13. Birthplace Germany

MOTHER
14. Maiden Name Selma Gebhard
15. Birthplace Germany

16 (a) Informant Mrs. Katherine Leitzman
(b) Address 3213 Stafford St

17 (a) Burial (b) Date thereof Oct 23 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mydow Ridge Cem.
Location S. Hilleary & Son

18 (a) Funeral director
(b) Address 6067 Harford Rd

19 (a) Oct 22 1947 (b) Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1947; at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1946 to Oct 21 1947, and that I last saw him alive on Oct 20 1947.

Immediate cause of death	Duration
uremia	2 Months
Due to chronic Nephritis with Hypertension	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Nathan Rauch M. D.

Address 206 S. Gilmor St. Date signed 10-23-47

PHYSICIAN

Underline the cause to which death should be charged statistically.

X

G56272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V122a

Registered No. G56272 (over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St. 6
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Angie Keys (ANGIE KEYS)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife: John Walter Keys

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-23-70

8. AGE: Years 76 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Sebhard Leimbach
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Laurence A. Keys
(b) Address 2428 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 23 1947 (Date rec'd by registrar) (b) Thomas J. Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1947, at 12-25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1947 to 10/21 1947 and that I last saw h[illegible] alive on 10/21 1947.

Immediate cause of death: RESPIRATORY FAILURE — Duration

Due to PERITONITIS

Due to PERFORATED ILIUM Due to STRANGULATED HERNIA

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: PERFORATED ILEUM

of autopsy: PERITONITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry A. Porter M.D.
Address Hosp. Date signed 10/24/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 656273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2231 McElderry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry G. Langham
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Anna Langham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22-1876

8. AGE: Years	Months	Days	If less than one day
71	5	30 29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired Farmer
11. Industry or business

FATHER
12. Name Langham
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Margaret M. Lutz
(b) Address 2231 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26-47 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran Church Cem. Location Golden Ring Rd. Balto. Co. Md.

18 (a) Funeral director John L. Miller
(b) Address 2034 Jefferson St

19 (a) Oct 22 1947 (Date received by local registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1947 at 345 M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 21 1945 to Oct 21 1947 and that I last saw him alive on Oct. 10 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	Hours.
Due to Arteriosclerotic Heart Disease	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Raan MD M. D.
Address 2413 E Monument St

VS 150

X 10/25/47

G56274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G56274

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 Brady Ave
(c) Hospital or institution: 25
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Fairfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Brady Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Cornelia Hairston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Clem

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26, 1878

8. AGE: Years 69 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Durham N. Carolina (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Charles Jackson Holloway
13. Birthplace Wake County N.C.

MOTHER
14. Maiden Name Georgiana Holeburton
15. Birthplace Asheville N.C.

16 (a) Informant Harvey Hairston
(b) Address 1500 Brady Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A.A. County Md

18 (a) Funeral director Mrs. W.H.G. Woodyard
(b) Address 1129 N. Caroline St

19 (a) Oct 22 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1947, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1947, to Oct 19 1947 and that I last saw h.er alive on Oct 19 1947.

Immediate cause of death: Congestive Heart Failure — Duration: 2 hr.

Due to: Hypertension Essential

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hubert Ford P. Commander M. D.

Address 2309 Druid Hill Date signed Oct 21 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

Registered No. G56275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 650 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katie
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 1-6-74

8. AGE: Years 73 | Months 9 | Days 15 | If less than one day ___ hr. ___ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Jeff Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Nellie Kane
15. Birthplace Md.

16 (a) Informant [illegible]
(b) Address 650 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Catholic Cem
Location Baltimore, Md

18 (a) Funeral director Mrs. Louis A. Stafford
(b) Address 1631 Druid Hill Ave

19 (a) OCT 22 1947 (Date received by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-47, at 6 Yo P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8-47, to 10-21 1947, and that I last saw Mr alive on 10-21 1947.

Immediate cause of death	Duration
Uremia	
Due to Carcinoma of prostate gland	
Due to	
Other Conditions Arteriosclerosis & Asthma (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
Date of autopsy October 22, 1947

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Perry B. Anderson M. D.
Address Johns Hopkins Hosp Date signed Oct 22 1947

056276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

Registered No. 056276

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 Linden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Thompson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1891

8. AGE: Years 56 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md. (town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name ? Martin
13. Birthplace Westmoreland Co. Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. George Thompson
(b) Address 1104 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1631 Druid Hill

19 OCT 23 1947 (b) (Date rec'd by Registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19, 1947 at 1 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1- 1945 to 10-19- 1947, and that I last saw h[illegible] alive on 10-19- 1947.

Immediate cause of death	Duration
Cardiac & Respiratory Failure	
Due to Arteriosclerosis	?
Due to Apoplexy	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
25. Signature Louis C. Harmon M. D.
Address 2340 Madison Date signed 10-22-47

Louis C. Harmon

G56277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G56277

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 - 20 1/2 St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 - 20 1/2 St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Priscilla Virginia Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1871

8. AGE: Years 76 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name Horace Smith
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Agnes Grant Tyler
15. Birthplace Frederick Co. Md.

16 (a) Informant Mrs. Henderson Kerr
(b) Address 1909 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1691 Division St. Bell Air

19 (a) OCT 23 1947 (Date rec'd by registrar) (b) Huntington Williamsburg Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1947, at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to Oct 20 1947 and that I last saw her alive on Oct 20 1947.

Immediate cause of death Organic Heart Disease — Duration Instants

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Garland Arnault
Address 1534 Druid Hill Ave Date signed Oct 22 1947

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No. 056278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 Washington Blvd DOA
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John S Bauman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-28-8313

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife MARGARET. BAUMAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 4 1900

8. AGE: Years 46 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation –

11. Industry or business –

FATHER 12. Name WILLIAM BAUMAN

13. Birthplace BALTO MD.

MOTHER 14. Maiden Name ELIZABETH. AULBACH.

15. Birthplace BALTO MD

16 (a) Informant MARGARET. BAUMAN

(b) Address 1214 WASHINGTON BLVD

17 (a) BURIAL (b) Date thereof 10-25-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS

Location A.A.Co.

18 (a) Funeral director Bernard C Hale

(b) Address 121 E West St

19 OCT 23 1947 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1947, at 3:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation due to
Illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10/22/47 at abt 12 3:00 P.M.

(b) Where did injury occur? 1217 Washington Blvd

(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No

(d) Means of injury Gas inhalation from ?

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 10/22/47

VS 181

656279 PERGRAM

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 108

Registered No. 656279

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 Houser St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Houser Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Pergram ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-9756

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine Pergram

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 10 1908

8. AGE: Years 39 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace (Town, county, and state) Stony Creek Va.

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Cupid Pergram
13. Birthplace Stony Creek Va

MOTHER
14. Maiden Name Enda Ruley
15. Birthplace Stony Creek Va

16 (a) Informant Josephine Pergram
(b) Address 531 Houser Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26 1947 (month) (day) (year)
(c) Cemetery or crematory SUSSEX, COUNTY
Location STONEY CREEK, VIRGINIA

18 (a) Funeral director Joseph A Apely
(b) Address 6 W Pratt Baltimore Md

19 (a) OCT 23 1947 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22, 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19, 1947 to Oct 22, 1947 and that I last saw h.im alive on Oct 22, 1947

Immediate cause of death: Lobar Pneumonia — Duration: 1 da

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature McDonald Bando M. D.

Address 2445 D. Hill Ave Date signed 10-23-47

VS 150

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 c

G56280 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 S. Payson St.
(c) Hospital or institution:

20 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 S. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche O. Krucky

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles Krucky
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) November 2, 1885

8. AGE: Years	Months	Days	If less than one day
61	11	20	hr. min.

9. Birthplace Elkton, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name George A. Wilson
13. Birthplace Northeast, Md.

MOTHER
14. Maiden Name Mary Barber
15. Birthplace Pennsylvania

16 (a) Informant Mr. Charles Krucky
(b) Address 606 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem
Location Baltimore, Md.

18 (a) Funeral director Wilbur Lamborn
(b) Address 4510 Liberty Heights Ave.

19 (a) 1947 (Date rec'd by registry) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1947; at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Oct 22 1947. and that I last saw her alive on 19

Immediate cause of death, Pulmonary Oedema

Due to Endocarditis

Due to Rheumatic Fever

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norbert C. Nitsch M. D.
Address 2151 Wilkens Ave. Date signed

Norbert C. Nitsch

G56281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 46E

G56281 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address N. Broadway

(c) Hospital or institution:

Church Home and Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos. 22 days

(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Hebbville

(If outside city or town limits, write RURAL and give town)

(d) Street No. Ridge & Dogwood Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lewis Oscar Stirn (Lewis Oscar Stirn)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Stirn

6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): July 30, 1888

8. AGE: Years: 59 | Months: 2 | Days: 22 | If less than one day: hr. min.

9. Birthplace: Hebbville, Md.

(Town, county, and state)

10. Usual Occupation: General Repairman

11. Industry or business: — Self

FATHER

12. Name: Fredrick Stirn

13. Birthplace: Balt. Md.

MOTHER

14. Maiden Name: Eva Weidmann

15. Birthplace: Balt. County

16 (a) Informant: Mrs. Margaret R. Stirn

(b) Address: Dogwood & Ridge Rds., Woodlawn

17 (a) Burial (b) Date thereof Oct 25, 1947

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: Mt. Olive Cemetery

Location: Randallstown, Md.

18 (a) Funeral director: Thelka Lawrence

(b) Address: 4510 Liberty Heights Ave.

19 (a) Huntingtown Williams, M.D.

(Date rec'd by registrar) Registrar

Oct 23 1947

150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1947, at 12 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1947, to Oct 22 1947, and that I last saw h[illegible] alive on Oct 22, 1947.

Immediate cause of death	Duration
Atelectasis Rt. Lower Lobe: Terminal Pulmonary Embolism	
Due to	
Due to	
Other Conditions: Carcinoma of Transverse Colon (Include pregnancy within 3 months of death)	

Date of operation: Oct 6, 1947

Major findings of operation: Carcinoma of Trans. Colon

of autopsy: Atelectasis Rt. Lower Lobe Terminal Pulmonary Embolism

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature: Joseph D'Antonio

Address: Church Home & Hosp. Date signed 10/23/47

M.D.

X

G56282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56282 Registered No. 170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-12
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 Hillsdale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Pondfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Late Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: House Wife
11. Industry or business

FATHER
12. Name: Jacob Cohen
13. Birthplace: Poland

MOTHER
14. Maiden Name: Eva Weiss
15. Birthplace: Poland

16 (a) Informant: Louis Pondfield
(b) Address: 3506 Wabash Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct, 24, 1947 (month) (day) (year)
(c) Cemetery or crematory: Shaarei Zion Cong Cem
Location: Hamilton Ave Rosedale

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

23 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1947, 8 p. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of Skull
Due to: Intracranial Hemorrhage

Other Conditions: Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 15/13
(a) Date of injury 10-22-47 7.40 p. M.
(b) Where did injury occur? 60 feet North Classen St. on Park Heights- Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian struck by auto

23. Signature: Earl L. Kruger, M.D.
Medical Examiner
Date signed 30 Oct 47

VS 181

G56283

BALTIMORE CITY HEALTH DEPARTMENT G56283
Registered No.

CERTIFICATE OF DEATH 14

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5745 Jonquil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE SHAPIRO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Norman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 2, 1899

8. AGE: Years 48 | Months | Days 20 | If less than one day hr. min.

9. Birthplace: Philadelphia Pa,
(Town, county, and state)

10. Usual Occupation
11. Industry or business: House Wife

FATHER
12. Name: Samuel Apfel
13. Birthplace: Austria

MOTHER
14. Maiden Name: Ida Barbour
15. Birthplace: Austria

16 (a) Informant: Norman Shapiro
(b) Address: 5745 Jonquil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25, 1947 (month) (day) (year)
(c) Cemetery or crematory: Mount Carmel Cemetery
Location: Philadelphia Pa

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

28 154
45 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1947, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13, 1947 to Oct 22 1947, and that I last saw HER alive on Oct. 22 1947

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to TUBERCULOUS MENINGITIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Susman M. D.
Address Sinai Hospital Date signed 10/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

G56284
AB-99596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V.12B

Registered No. G56284

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Low Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Edward Poulson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15-1910

8. AGE: Years	Months	Days	If less than one day
37	9	7	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Robert Grant Poulson
13. Birthplace Virginia

MOTHER
14. Maiden Name Alverta Young
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26. 1947 (month) (day) (year)
(c) Cemetery or crematory Sawgrasville Cem.
Location Accomac Co. Va

18 (a) Funeral director Chiozo & Wilson
(b) Address 1000 Brantly ave

19 (a) Oct 23 1947 (Date filed by registrar) (b) Lexington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1947, at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22- 1946, to 10-22 1947, and that I last saw h im alive on 10-22- 1947

Immediate cause of death Pulmonary Tuberculosis, Bilateral far advanced — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 3-8-46
Major findings of operation: Rt Pneumothorax
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leigh W. Parker M. D.
Address Balt City Hosp Date signed 10-22-47

X

G56285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G56285

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Payson Drs
(c) Hospital or institution: West Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 E. Madison St (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) **FULL NAME** Helen P. King

3 (b) If veteran, name war — No
3 (c) Social Security Account No. NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph F. King
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 6/25/96

8. AGE: Years 41 | Months 3 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Pittsburgh PA (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

MOTHER / FATHER
12. Name Andrew Frank
13. Birthplace Pittsburg Pa
14. Maiden Name Louise Schwer
15. Birthplace Pittsburg Pa

16 (a) Informant Mary Lou King
(b) Address 2821 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Chas. F. Evans + Son
(b) Address 118 W. Mt Royal Ave

19 OCT 23 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1947 at 6:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1947 to 10-21 1947, and that I last saw her alive on 10-21 1947.

Immediate cause of death	Duration
Bilateral Bronchial Pneumonia	
Due to Pleural Effusion Left	
Due to Myelogenous Leukemia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Liebman M.D.
Address West Balto Dr's Hosp Date signed 10-22-47

VS 150

1102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056286 BC# 83357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 056286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dan Allen Jones III

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	—

6 (b) Name of husband or wife 7/9/47
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	3½	13	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Dan Allen Jones #2
13. Birthplace Raeford, N. C.

MOTHER
14. Maiden Name Dora Deloroms Ross
15. Birthplace Raeford N. C.

16 (a) Informant Dora D. Jones
(b) Address 1015 E. Monument St

17 (a) Burial (b) Date thereof Oct. 24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Chas O. Wilson

18 (a) Funeral director 10 to Brantly Av
(b) Address 1010 Brantly Ave

19 OCT 23 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22-1947, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquisition & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Miliary Tuberculosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malone M.D.
Medical Examiner.
Date signed 10-23-47

X

656287 BC# 78524 SORTINO

BALTIMORE [illegible] DEPARTMENT

CERTIFICATE OF DEATH

170c

656287
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Left 2
(e) Length of stay in Baltimore (yrs., mos., or days) Left 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Hatton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Christine Sortino

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1942

8. AGE: Years 5 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Christopher F. Bordyko
13. Birthplace Balto Md

MOTHER
14. Maiden Name Madeline E. Bordy
15. Birthplace Balto Md

16 (a) Informant Christopher F. Sortino
(b) Address 510 Williams St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24 1947 (month) (day) (year)
(c) Cemetery or crematory Bordyko's
Location A. G. P. Co.

18 (a) Funeral director E. Kerigan & Sons
(b) Address 1420 S. Charles St

19 (a) OCT 23 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-1947, at 10:12 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Partial Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of pelvis
Fracture of ribs.
Due to: Rupture of diaphragm.
Rupture of spleen

Other Conditions: Laceration of perineum

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/21/47 at 3:15 P.M. 24/4
(b) Where did injury occur? Port Ave & Jackson
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Ped. struck by truck

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10-21-47

VS 191

G56288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G56288

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LINDEN AVE. AND MADISON ST.
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4909 Gordon and (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FLORIAN LEITSCHUH (Florian Leitschuh)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Clara A. Schindler
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Nov. 6th., 1868

8. AGE: Years 78 ### | Months 11 | Days 15 | If less than one day ######## min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Rail-Road

FATHER
12. Name Casper Leitschuh
13. Birthplace Germany

MOTHER
14. Maiden Name Antonia Rohmise
15. Birthplace Germany

16 (a) Informant Albert Leitschuh (Son)
(b) Address 4909 Gordon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 23 1947 (Date rec'd by registrar) (b) Tunstall Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1947 at 5:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1947 to 10-21 1947, and that I last saw him alive on 10-21 1947.

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to SENILITY, LOBULAR PNEUMONIA	
PERITONITIS	
Due to CARCINOMA OF TRANSVERSE	
COLON, COLOSTOMY	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10-16-47
Major findings of operation: Intestinal Obstruction
of autopsy: CARCINOMA OF TRANSVERSE COLON

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul G. Herold M. D.
Address Md. General Hosp Date signed 10/21/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 056289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern Avenue
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) None

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1630- Aisquith Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN T. ~~BEACHER~~ (John T. Beecher) Sr.)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-12-6821

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mamie W. Frederick

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1884

8. AGE: Years 63 ## | Months 9 | Days 4 | If less than one day ##### hrs. ##### min.

9. Birthplace Baltimore County
(Town, county, and state)

10. Usual Occupation Maintenance-Man

11. Industry or business Morton-Sign Co.

FATHER
12. Name John Henry Beecher
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Fannie Baker
15. Birthplace Baltimore County

16 (a) Informant Mary E. Hammen (Daughter)
(b) Address 3044 Oak Forrist Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Memetery
Location E. North Avenue Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1947, at 4 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute congestive heart failure

Due to Coronary artery disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emily Bright M.D.
Medical Examiner.

Date signed 10-22-47

656290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(47)

Registered No. 656290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2619 Eastern ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2619 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Kyle

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Annie Kyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1871

8. AGE: Years	Months	Days	If less than one day
76	7		hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Henry Kyle
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Collison
15. Birthplace Maryland.

16 (a) Informant John H. Weil
(b) Address 717 Elmwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 OCT 23 1947 (Date rec'd by registrar) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21, 1947, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1947 to [illegible] 1947 and that I last saw h[illegible] alive on [illegible] 1947.

	Duration
Immediate cause of death Cerebral arterio[illegible]	2 days
Due to Chronic endocarditis	7 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed [illegible]

G56291 BCH b 91382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G56291 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town, write RURAL)
(d) Street No. 2012 Fleet St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL GESINA

3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-13-47
8. AGE: Years — Months — Days 1 | 12. If less than one day 36 hr. — min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Dorothy Gesina
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loc Johns Hopkins Medical Schoo OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (BT) OCT 23 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14-1947, at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 13th 1947, to OCT 14th 1947, and that I last saw her alive on OCT 14th 1947.

Immediate cause of death	Duration
ASPHYXIA NEONATORUM	
Due to ATELECTASIS	
Due to PREMATURITY	
Other Conditions ? SEPTICEMIA	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Spencer M.D.
Address Johns Hopkins Hosp. Date signed Oct 14 1947
Harriet Lane Home

G56292

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 94a

✓ G56292

Reg. Dist. No.

1. PLACE OF DEATH: County 1623 W. North Ave

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County

City or town Balto Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 1623 W. North Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sadye K. Marchant

3.(b) Social Security Number

4. Sex: Female

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Dr Cecil S. Marchant

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 24 1879

8. AGE: Years 67 | Months 9 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER 12. Name: Simon Katz

13. Birthplace: Phila Pa

MOTHER 14. Maiden name: Mary Katz

15. Birthplace: Germany

16. Interment: Dr Cecil S. Marchant

Address: 1623 W. North Ave

17. ..... Date thereof: Oct 24/47 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Oheb Shalom Cem

Location: O Domenh St

18. Funeral director: J. Ahrens Co

Address: 2432 Reisterstown Rd.

OCT 23 1947 Huntington Williams, M.D.

(Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1947, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1946 to October 22 1947, and that I last saw h.. alive on October 22 1947

Immediate cause of death: Coronary Thrombosis — DURATION: 3 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Morris W. Steinberg M.D. or other

Address: 410 N. Hilton St Date signed: Oct 24 1947

X

G56293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G56293
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Kennaugh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert S. VESSELLS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: Colored

6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Beauregard Vessells
13. Birthplace Va.

MOTHER
14. Maiden Name Carrie Kay.
15. Birthplace Va.

16 (a) Informant Carrie Vessells
(b) Address 1815 Kennaugh St.

17 (a) Burial (b) Date thereof 10/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. H. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 927 N. Mount St.

19 OCT 24 1947 (b) Hunting for Williams Hill
(Date rec'd by registrar)

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1947, at 1 2:0 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration
Edema of lungs
~~Due to~~ Edema of brain

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/25/47

656294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

656294 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1048 N. Eden
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b). County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1048 N. Eden (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bettie Payne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife George Payne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1878

8. AGE: Years	Months	Days	If less than one day
69	-	-	hr. min.

9. Birthplace Arkansas (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER
12. Name Mary Wolfe
13. Birthplace Arkansas
14. Maiden Name Dafforonia ?
15. Birthplace Arkansas

16 (a) Informant Ellen M. Cool
(b) Address 1048 N. Eden

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Cem.
Location Hale Chapel Balto Co. Md.

18 (a) Funeral director Metropolitan Fun. Homes Inc.
(b) Address 927 N. Mount St.

19 (a) Oct 1947 registered (b) Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1947 to Oct 22 1947 and that I last saw h alive on Oct 22 1947

Immediate cause of death: Acute Pulmonary Congestion — Duration 2 days
Due to: Carcinoma of Lung — 2 mos.
Due to: Gen'l Carcinomatosis — 1 mo.
Other Conditions.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. E. Berry M. D.
Address 1420 E. Chase Date signed 10-23-47

VS 150

X

G56295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G56295 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3820 Norfolk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Norfolk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman Seidler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rebecca

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years: 80 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name: Aaron
13. Birthplace: Russia

MOTHER
14. Maiden Name: Chia
15. Birthplace: Russia

16 (a) Informant: Rebecca Seidler
(b) Address: 3820 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-24-47 (month) (day) (year)
(c) Cemetery or crematory: Beth Tfiloh
Location: Windsor Mill Road

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2640 Eutaw Place

19 (a) OCT 24 1947 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23-1947 at 10 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1947 to Oct 23 1947 and that I last saw h. alive on Oct 23 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 hrs

Due to:

Due to: Gen. Arteriosclerosis — Duration: 5 yrs

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: M D Baylin
Address: 2040 Eutaw Date signed: 10/23/47

056296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 056296

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Oswego Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MR SAMUEL COHEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Dessie
15. Birthplace Russia

16 (a) Informant Fannie Cohen
(b) Address 2700 Oswego Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herzog Rym

18 (a) Funeral director Jack Lentos Inc
(b) Address 700 Eutaw Place

19 (a) OCT 24 1947 (Date rec'd by registrar) (b) Custis for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1947 at 2 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1947 to Oct 23 1947 and that I last saw h in alive on Oct 23, 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other Conditions Generalized Arteriosclerosis Chronic Cardio-Vasc. disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allan J. Lindenberg M. D.
Address Sinai Hospital Date signed 10-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

83a

G56297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G56297

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4819 Richard Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4819 Richard Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Huntley Baskey

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Melville H. Baskey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 1856

8. AGE: Years	Months	Days	If less than one day
91	3	3	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Conrad Lerp
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Richers
15. Birthplace Balto Md.

16 (a) Informant Mrs Ella M. Huntley
(b) Address 4819 Richard Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Oakwood Cem.
Location Baltimore

18 (a) Funeral director A. Howard Evans & Son
(b) Address 1400 N. Charles St.

OCT 24 1947 (Date rec'd by registrar) Funeral for Williams Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22, 1947, 9:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 1947 to Oct. 22 1947, and that I last saw h[illegible] alive on Oct. 21 1947

Immediate cause of death: Obstruction of Lung — Duration 8 days
Due to: Coronary Thrombosis — 3 days
Due to: Coronary Sclerosis
Other Conditions: Old age.
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Leo L Mertz M. D.
Address [illegible] Date signed Oct 24 1947

X

G56298 ✓ G56298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 W. Lanvale st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 W. Lanvale st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE L. BISH

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: John A. Bish
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 17, 1885

8. AGE: Years	Months	Days	If less than one day
62	1	5	hr. min.

9. Birthplace: Littlatown, Pa.
(Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business

FATHER
12. Name: John R. Byers
13. Birthplace: Libertytown, Md.

MOTHER
14. Maiden Name: Georgiana Stear
15. Birthplace: Pennsylvania

16 (a) Informant: Miss Helen Bish, daughter
(b) Address: 3002 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/47 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: BALTIMORE, MD.

19 (a) (Date received by registrar) (Signature of registrar)

VS 150 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1947, at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30, 1947, to Oct. 22, 1947, and that I last saw her alive on Oct. 22, 1947.

Immediate cause of death	Duration
hypostatic pneumonia	2 days
Due to cerebral thrombosis	3 mo.
Due to arterial hypertension	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: George A. Kemp M. D.
Address 3030 Edmondson Ave. Date signed 10/23/47

656299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

656299 Registered No. 876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Murdock Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BENJAMIN HARRISON BAYNARD

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ada A. Baynard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1889

8. AGE: Years	Months	Days	If less than one day
58	7	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Insurance Agt.
11. Industry or business

FATHER
12. Name William H. Baynard
13. Birthplace Smyrna, Del.

MOTHER
14. Maiden Name Hester Gorsuch
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Ada A. Baynard
(b) Address 502 Murdock Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 24 1947 (Date rec'd by registrar) Hunter for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1947 at 6.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1947 to Oct 23 1947 and that I last saw h.s alive on Oct 22 1947

Immediate cause of death	Duration
respiratory failure	
Due to NEURONITIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. C. Durrall Jr. M.D. M. D.
Address University Hosp. Date signed Oct 23

X

656300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 656300

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1571 Ridgely St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1571 Ridgely St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred P. Clark

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lillian Becker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16th 1892

8. AGE: Years 55 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Restaurant Keeper

11. Industry or business Self

FATHER
12. Name James E. Clark
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Rena E. Hart
15. Birthplace Lancaster Pa.

16 (a) Informant Mrs Lillian J. Clark
(b) Address 1571 Ridgely St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 23 47 (month) (day) (year)

(c) Cemetery or crematory Mt. Cathedral Cem.
Location 4509 Old Frederick Rd.

18 (a) Funeral director John F. Gawn & Son
(b) Address 901-03 Hollins St.

19 (a) 24 1947 (Date rec'd by Registrar) (b) [illegible]

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23rd 1947 at 3.1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12-1947 to Oct. 23-1947 and that I last saw him alive on Oct. 23. 1947

Immediate cause of death	Duration
Coronary Occlusion	- 4 hrs
Due to Hypertension	about
Due to & arterio-sclerosis	2-3 yrs
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Herman Seidel

Address 2424 Eutaw Pl. Date signed 10/23/47 (M. D.)

G5$301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 Washington Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Balbina Rheinne

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Late John Rheinne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 31 1878

8. AGE: Years 69 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Home work
11. Industry or business at Home

FATHER
12. Name Michael Stefanski
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Unknown
15. Birthplace Germany

16 (a) Informant Mr. John V. Lozanski
(b) Address 1204 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Germans Mill Rd.

18 (a) Funeral director John J. Lozanski Son
(b) Address 9603 Hollins St.

19 (a) OCT 24 1947 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22nd 1947, at 11 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1946, to Oct 22 1947, and that I last saw her alive on Oct 22 1947.

	Duration
Immediate cause of death: Pulmonary Edema	1 day
Due to: Hypertensive Heart Disease	6 months
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place)* While at work?
(e) Means of injury

23. Signature Johns P. Urlock, Jr.
Address 1227 Wash. Blvd. Date signed M. 10 D. 23/47

X

656302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 656302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2409 Harlem Ave.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FELICITAS RESSMEYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry F. Ressmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1867

8. AGE: Years	Months	Days	If less than one day
80	3	13	hr. min.

9. Birthplace New York City
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Frederick Steng
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Katherina Wollschlager
15. Birthplace Germany

16 (a) Informant Rev. Rudolph S. Ressmeyer
(b) Address 2516 Edmondson Ave.

17 (a) Burial (b) Date thereof 10/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location New York, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 OCT 24 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1947, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1946 to Oct 22 1947 and that I last saw her alive on Oct 22 1947.

Immediate cause of death	Duration
Carcinoma of Head of Pancreas	7
Due to	
Due to	
Other Conditions Arteriosclerosis cardio vascular disease	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl P. Rossing M. D.
Address 1326 W. Lombard St. Date signed 10/24/47

6-TRANSCRIPTS

G56303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √94a

Registered No. G56303

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 N. Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Ruth A. Hartzell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-29-92

8. AGE: Years	Months	Days	If less than one day
55	3	24	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Cashier
11. Industry or business Restaur

FATHER
12. Name David C. W. Hartzell
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Martha Ann Annis
15. Birthplace Baltimore, Maryland

16 (a) Informant Hospital Records
(b) Address 2025 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director Loring Rogers
(b) Address 5005 Park Heights Ave.

19 OCT 24 1947 (Date rec'd by registrar) (b) Hunting for Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1947 at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1947 to 10-23 1947, and that I last saw h alive on 10-23 1947

Immediate cause of death Coronary occlusion — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
At autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature George W. Fenton M. D.
Address Bon Secours Hosp Date signed 10-25

656304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1828

656304 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Earl Court Apts
(c) Hospital or institution: Sts Paul & Preston Sts

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Earl Court Apts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Thomas Shackelford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Rachel M. Shackelford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 1856

8. AGE: Years 91 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Wilmington N.C.
(Town, county, and state)

10. Usual Occupation Business

11. Industry or business Insurance

FATHER
12. Name James Shackelford
13. Birthplace Virginia

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Richard T Shackelford
(b) Address Woodbrook Balto 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24 194 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Henry H Eschenburg & Sons
(b) Address 2400 Eutaw & Orchard Sts

19 (a) OCT 24 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Oct 1947, at 1:46 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947 to Oct 22 1947. and that I last saw [illegible] alive on Oct 22 1947.

Immediate cause of death: Cerebral Thrombosis — Duration

Due to: Senescence

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter A Bastian M.D.
Address 1101 St Paul St Date signed Oct 23-47

VS 150

G56305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56305 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Be sure to state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 W. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 W. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Tolson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Zachary Tolson
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1879.

8. AGE: Years	Months	Days	If less than one day
68	2	21	hr. min.

9. Birthplace Northumberland Co., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ralph A. Pryor.
13. Birthplace Heathsville, Va.

MOTHER
14. Maiden Name Ann Craig
15. Birthplace Heathsville, Va.

16 (a) Informant Mrs. Mary E. Davis.
(b) Address 618 W. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26, 1937 (month) (day) (year)
(c) Cemetery or crematory Heathsville, Va.
Location Virginia

18 (a) Funeral director Miss Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Oct 24 1937 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1937 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1 1937 to Oct 22 1937 and that I last saw h[illegible] alive on Oct 22 1937

Immediate cause of death	Duration
Cerebral hemorrhage	21 days
Due to Hypertension	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [signature]
Address 74 W. Lee St. Date signed Oct 25 1937 M.D.

G56306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G56306

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 Brune St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Brune St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Montague.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife George Montague

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1886

8. AGE: Years: 61 | Months: 1 | Days: 28 | If less than one day: hr. min.

9. Birthplace West Moreland Co. Va.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant Bernard Montague.
(b) Address 644 Pentania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

OCT 24 1947 (Date rec'd by registrar) (b) Lucretia for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1947 at 8:40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1947 to 10/20 1947. and that I last saw h.er alive on 10/20 1947

Immediate cause of death: Cancer of Rose — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Evan A. Eccles, M. D.

Address 601 N. Calhoun St. Date signed 10/23/47

X

G56307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

Registered No. G56307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Caton & Wilkens Aves.
(b) Street address ~~2005 Bank St.~~
(c) Hospital or institution: Jenkins Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 Bank St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

3 (a) FULL NAME Agatha M. Kadulska

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, (widowed) or divorced.
6 (b) Name of husband or wife John Kadulska
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1859

8. AGE: Years 88 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Kasper Kurek
13. Birthplace Poland

MOTHER
14. Maiden Name Catherine Czaja
15. Birthplace Poland

16 (a) Informant Brother Gabriel Dom
(b) Address Folly Quarter Catonsville
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County
18 (a) Funeral director John H. Weber
(b) Address 411 E. Chester Street
19 (a) OCT 24 1947 (Date) (b) Registrar's signature Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1947 at 1:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1941 to Oct 21 1947 and that I last saw h.e.r. alive on Oct 21 1947

Immediate cause of death	Duration
Congestive heart failure	
Due to Hypertensive CVD.	
Due to Generalized arteriosclerosis	
Other Conditions Hypertrophic arthritis	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert J. Lueckes
Address 411 Agnes Loop. Date signed Oct 24, 1947

VS 150

G56308

BALTIMORE CITY HEALTH DEPARTMENT + 937

CERTIFICATE OF DEATH

Registered No. G56308

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 939 Gorsuch Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County Queens
(c) City or town Jackson Heights NYC (If outside city or town limits, write RURAL and give town)
(d) Street No. 3247-84th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Donohue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Patrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1876

8. AGE: Years 71 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick Walsh
13. Birthplace Ireland

MOTHER
14. Maiden Name Kathryn Mitchell
15. Birthplace Ireland

16 (a) Informant Dr. Edmund Donohue
(b) Address 939 Gorsuch Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 25 47 (month) (day) (year)
(c) Cemetery or crematory St Johns Cemetery
Location Brooklyn New York

18 (a) Funeral director Wm Cook Funeral
(b) Address 121 St Paul St

19 (a) OCT 24 1947 (Date rec'd by registrar) (b) Waiting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1947 at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1947 to Oct 23 1947, and that I last saw her alive on Oct 23 1947

Immediate cause of death ? Coronary Occlusion — Duration ?

Due to Arteriosclerotic Heart Disease — Duration ?

Due to

Other Conditions Malnutrition — Duration ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund A Donohue M. D.
Address Medical Arts Bldg Date signed Oct 27 1947

VS 150

656309 437320 -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 56E

Registered No. 656309

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Pittsburg, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1950 Broadway Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nell Fleece

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Sep.
6 (b) Name of husband or wife: 10-25-07
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 10-25-07

8. AGE: Years	Months	Days	If less than one day
39	11	29	hr. min.

9. Birthplace: Pa. (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business

FATHER
12. Name: Frank Mancuso
13. Birthplace: Italy

MOTHER
14. Maiden Name: Josephine Bubba
15. Birthplace: Italy

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 24-47 (month) (day) (year)
(c) Cemetery or crematory Pittsburg Pa
Location Penna

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul Street

19 (a) OCT 24 1947 (Date rec'd by registrar) (b) Evangeline White Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-24- 1947 at 6 15/a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29- 1947 to 10-24 1947 and that I last saw h[illegible] alive on 10-24- 1947.

Immediate cause of death	Duration
Chordoma of Skull in posterior Fossa	4 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10/9/47
Major findings of operation: Chordoma of Skull
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George L. Cutbush
Address Johns Hopkins Hosp. Date signed Oct 27, 47

X

056310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

102

Registered No. 056310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 Montebello Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yr. 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Montebello Terrace (If rural give location)
(e) Citizen of foreign country? S (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah F. Sheppard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Dr. James Sheppard

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1870

8. AGE: Years 77 | Months 4 | Days 14 | If less than one day: hr. min.

9. Birthplace Loudon, Tennessee (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Cook
13. Birthplace Tennessee

MOTHER
14. Maiden Name June Irvin
15. Birthplace Tennessee

16 (a) Informant Dr. J. Douglas Sheppard
(b) Address 1063 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Springfield Cem
Location Peoria, Illinois

18 (a) Funeral director Geo. F. Holland
(b) Address 1631 Druid Hill Ave

19 (a) Oct. 24 1947 (Date received by Registrar) (b) Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6, 1946 to Oct. 21, 1947, and that I last saw h[illegible] alive on 10-21-1947.

	Duration
Immediate cause of death: Hypertension	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George F. Page M.D.
1816 N. Monroe St. (?) Address
Date signed Oct 24 1947

X

656311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 656311

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 58 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 WALDORF AVE
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

5 13

3 (a) FULL NAME ROSE — BLOOM

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife ADOLPH BLOOM
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) UNK 1877

8. AGE: Years	Months	Days	If less than one day
70	—	—	hr. min.

9. Birthplace ? RUSSIA
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name WOLF NEWMAN
13. Birthplace ? RUSSIA

MOTHER
14. Maiden Name JENNIE PUSHKIN
15. Birthplace ? RUSSIA

16 (a) Informant DAVID BLOOM
(b) Address 4016 BENNER RD

17 (a) BURIAL (b) Date thereof 10 26 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location 6800 Germans Hill Road

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 4734-36 W. North Ave.

19 (a) OCT 24 1947 (b) Huntingtown Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Oct 1947, at 8:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Oct 1947 to 23 Oct 1947, and that I last saw h.e.r. alive on 23 Oct 1947

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	
Due to CEREBRAL METASTASES	3 WKS
Due to ADENOSARCINOMA OF LEFT BREAST	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4 AUGUST 1947
Major findings of operation: Adenoca, breast by gradatim & superficial ulceration and axillary metastases
of autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred B Agnew Jr M. D.
Address Norman's Hosp. Date signed 29 Oct 47

X

G56312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G56312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2706 W. Rogers Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 W. Rogers Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry R. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-2310

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	M. married

6 (b) Name of husband or wife Julia Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1876

8. AGE: Years	Months	Days	If less than one day
70	11	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Lin-o-type Operator
11. Industry or business Baltimore Sun Paper

FATHER
12. Name Thomas Miller,
13. Birthplace unknown

MOTHER
14. Maiden Name Cleantha Kaufman,
15. Birthplace unknown

16 (a) Informant Mrs. Julia M. Miller,
(b) Address 2706 W. Rogers Ave.,

17 (a) burial (b) Date thereof 10/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director C. Vernon Lemmon,
(b) Address 4611 Park Heights Ave.,

19 (a) 10-24-1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

001

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1947 19 at 8:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17, 1947 to Oct. 23, 1947. and that I last saw him alive on Oct. 23, 1947.

Immediate cause of death Hypertension Cardio-Vascular Disease with decompensation

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration: 2 weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Simmonds M.D.
Address 511 Medical Arts Bldg Date signed 10/24/47

VS 150

656313

AB-107300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered No. 656313

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 East Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Torres

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Clara (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24- 1877

8. AGE: Years	Months	Days	If less than one day
70	8	29	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Charles E. Torres (D
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Marian W. Tustin (D
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-47 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location city

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount & 22nd

OCT 24 1947 (Date rec'd by registrar) (b) Washington Hillsboro Md. Registrar

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Oct. 23 1947, at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4- 1947 to 10-23 1947, and that I last saw him alive on 10-23- 1947

Immediate cause of death	Duration
Uremia	—
Due to Hypertensive C.V.R.D.	yrs.
Due to	
Other Conditions	new

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Bodine M.D.
Address Balto Co. Date signed 10-27-47

X

G56314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G56314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 Beaumont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Beaumont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anthony Starnakas

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 215-01-0678

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name
15. Birthplace Lith

16 (a) Informant Margaret Starnakas
(b) Address 904 Beaumont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd

18 (a) Funeral director Joseph Kasmakas Son
(b) Address 602 Washington Blvd

19 OCT 24 1947 Registered by Registrar, Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1947, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1947 to 10-22 1947, and that I last saw h. alive on 10-22 1947.

Immediate cause of death: Coronary Artery Disease — Duration: 6 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] Address 3217 Fort Ave. Date signed 10/24/47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. 56315

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Walker & Sherwood Apts Short (If rural give location) Sax. 1043
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Kincaid

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-4520

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1907

8. AGE: Years	Months	Days	If less than one day
43	—	26	hr. min.

9. Birthplace Deerfield Va
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name Dennis Mickael Kincaid
13. Birthplace Deerfield Va

MOTHER
14. Maiden Name Lena F. Rhodes
15. Birthplace Buffalo Gap. Va

16 (a) Informant
(b) Address Walker ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25/47 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Balto. Md

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 OCT 24 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1947, at 10 23 M

21. I certify that I took charge of the remains described above, held an Inspection and Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Lis death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diabetes mellitus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George B. Merrill M.D.
Medical Examiner.
Date signed 10/23/47

VS 181

456316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 456316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3438 Chestnut Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3438 Chestnut Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E. Cornell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Beda Bossom Cornell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) oct. 7th. 1876

8. AGE: Years	Months	Days	If less than one day
71	0	16	hr. min.

9. Birthplace Savage Md. (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Augusta Cornell
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah
15. Birthplace Maryland

16 (a) Informant Mrs. Beda B. Cornell
(b) Address 3438 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Gerard Bayer Jr.
(b) Address 1512 Hollins St.

19 (a) OCT 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1947 to Oct 23 1947 and that I last saw h[illegible] alive on Oct 22 1947.

Immediate cause of death	Duration
Myocarditis	
suffering	
Due to Cerebral hemorrhage	1
Due to Senile debility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Wm. Arnold M. D.
Address 3429 Chestnut Ave. Date signed Oct 24 '47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 056317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2231 W. Lexington, St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 W. Lexington, St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John Martin Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Margaret Shanahan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/22/892

8. AGE: Years	Months	Days	If less than one day
55	5	30	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Balto. & Ohio, RR

FATHER
12. Name John Burns
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Feeley
15. Birthplace Ireland

16 (a) Informant Margaret Burns
(b) Address 2231 W. Lexington, St.

17 (a) Burial (b) Date thereof 10-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Edmondson Ave.

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Dibble St.

19 (a) OCT 24 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947, to October 23 1947, and that I last saw him alive on October 23 1947

Immediate cause of death	Duration
Arterio-sclerosis and hypertension.	6 Months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation ---
Major findings of operation: ----
of autopsy: ---

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ---
(b) Date of occurrence --- at -- M
(c) Where did injury occur? ---
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? -- While at work? --
(Specify type of place)
(e) Means of injury ---

23. Signature Harold S. Thurston M. D.
Address 1945 W. Balto. St., Date signed 10-24-47

X

56318 C.M.E. 91562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(83)

Registered No. 56318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Years
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Market Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Edward J. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25-1867

8. AGE: Years	Months	Days	If less than one day
80	2	23	hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Adam
13. Birthplace New Jersey

MOTHER
14. Maiden Name Elizabeth Adams
15. Birthplace New Jersey

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 24 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1947, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1945 to Oct. 18 1947, and that I last saw h. in alive on Oct. 18 1947

Immediate cause of death	Duration
Bronchopneumonia	days
Due to	
Due to	
Other Conditions Hypertensive Vascular Disease; Hemiplegia, right	years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 10-21-47

VS 150

656319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 830

Registered No. 656319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hillcrest Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town English Consul - 27 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 Daisy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Lanciotti

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife Alfred Lanciotti
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Sept 22 1891

8. AGE: Years	Months	Days	If less than one day
56	1	-	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Dente
13. Birthplace Italy

MOTHER
14. Maiden Name Catherine Basigalupo
15. Birthplace Italy

16 (a) Informant Alfred Lanciotti
(b) Address 2736 Daisy Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25 '47 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location

18 (a) Funeral director Glenwood G. Donovan
(b) Address 3615-17 Christian Ave

OCT 25 1947 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1947 to 10-22 1947 and that I last saw h[illegible] alive on 10-22 1947.

Immediate cause of death	Duration
(a) cerebral accident	10 day
Homiplegia	
Due to (b) Hypertension arteriosclerosis	?
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Duncan M. D.
Address Medical Arts Bldg Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

56320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G56320

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to give correct age in each case. Where death occurred in a hospital or institution, the street address of the home of the deceased must be given. Especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 Cecil Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Cecil Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY J. VanGASKEN

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Carolina Van Gasken
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 18, 1856

8. AGE: Years: 91 | Months: 6 | Days: 6 | If less than one day: hr. min.

9. Birthplace Smyrna, Del. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Penna. R. R.

FATHER
12. Name John Van Gasken
13. Birthplace Delaware

MOTHER
14. Maiden Name Unknown
15. Birthplace Delaware

16 (a) Informant Mrs. Stella H. Herman
(b) Address 2015 Cecil Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/25/47 (month) (day) (year)
(c) Cemetery or crematory
Location Wilmington, Del.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 25 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1947, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1947 to Oct. 24 1947 and that I last saw him alive on Oct. 24, 1947.

Immediate cause of death	Duration
Coronary Thrombosis	6 hrs.
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions Chronic Arthritis	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert D. Ringwald M.D.
Address 1613 E. North Ave. Date signed 10-24-47

47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G56321

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3234 Kenyon Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3234 Kenyon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAY SILBERZAHN

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George W. Silberzahn
6 (c) If alive, give age: X years

7. Birth date of deceased (mo., day, yr.): March 9, 1877

8. AGE: Years 70 | Months 7 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Hoffman
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mollie Kraft
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Dora Medinger
(b) Address: 3234 Kenyon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/47 (month) (day) (year)
(c) Cemetery or crematory: Mount Olivet Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 OCT 25 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH October 22 1947, at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1947 to Oct 22 1947; and that I last saw h[illegible] alive on Oct 21 1947

Immediate cause of death	Duration
Due to Metastasis of Carcinoma of Uterus.	
Due to	
Other Conditions Arteriosclerotic Cardio-Vascular disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: [signature]
Address 3400 Eutaw Pl. Date signed 10/31/47

V S 150

656322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 457

Registered No. 656322

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 S. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 S. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fred Lem Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-0526

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Alberta (Evans)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1903

8. AGE: Years	Months	Days	If less than one day
44	1	16	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER 12. Name Arthur Bowen
13. Birthplace South Carolina

MOTHER 14. Maiden Name Lucy Clifton
15. Birthplace South Carolina

16 (a) Informant Mrs. Alberta Bowen
(b) Address 329 S Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25 1947 (month) (day) (year)
(c) Cemetery or crematory Morgan Chapel
Location Woodlawn Md

18 (a) Funeral director Harry H Wiltze
(b) Address 4101 Edmondson Ave

19 (a) Oct 25 1947 (Date rec'd by Registrar) Huntington Willia[illegible]

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1947 at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1946 to Oct 22 1947 and that I last saw h[illegible] alive on Oct 22 1947

Immediate cause of death Carcinoma of rt lower jaw — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2033 Wilkens Av Date signed 10/31/47

X

G56323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56323 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hampnett Avenue
(c) Hospital or institution:
Pineridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (Baltimore) Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 Anneslie Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Gracey

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wodowed

6 (b) Name of husband or wife Bertha Elizabeth
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1862

8. AGE: Years	Months	Days	If less than one day
85	1	2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Clerk - retired
11. Industry or business Gas & Electric Co.

FATHER
12. Name Benjamin M. Gracey
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Herbert A. Gracey
(b) Address 716 Anneslie Road

17 (a) Burial (b) Date thereof 10/ /47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 OCT 25 1947 Huntington Williams, M.D.
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Oct 23 1947, and that I last saw h— alive on Oct — 1947

Immediate cause of death — Duration
Arteriosclerotic
Peripheral Vascular Disease
Due to
Due to
Other Conditions Diabetes Pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Percy Kearney M. D.
Address 7 E Chase Date signed 10/24/47

97

G56324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56324

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and entered. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 192 Ellamont St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 192 Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Harry Giardina

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	white	

6 (b) Name of husband or wife Angelina
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16-1885

8. AGE: Years	Months	Days	If less than one day
61	10	8	hr. min.

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Fruit Dealer
11. Industry or business

FATHER
12. Name Ruggio Giardina
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Angelina Giardina
(b) Address 192 E. Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4100 Old Frederick Rd.

18 (a) Funeral director Joseph Fanaro Sons
(b) Address 2013 Greenmount Ave

19 OCT 25 1947 (Date rec'd by registrar) (Signature of registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24 1947, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1947, to 10-24 1947, and that I last saw him alive on 10-24 1947.

Immediate cause of death Coronary Thrombosis — Duration 10 min

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation Not done

Major findings of operation

of autopsy Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon Coleman M. D.
Address 101 Taylor Ave St Date signed 10-25-47

X

G56325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G56325

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 Longwood Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Longwood Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline V. Firor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Oliver T. Firor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1857

8. AGE: Years	Months	Days	If less than one day
90	6	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name D. William H. Cook
13. Birthplace Baltimore, Md. Germany

MOTHER 14. Maiden Name Katherine Becker
15. Birthplace Germany

16 (a) Informant Dr. W. M. Firor
(b) Address 107 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ward's Chapel
Location Randallstown, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) OCT 25 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943, to 1947; and that I last saw him alive on Aug. 26 1947

Immediate cause of death	Duration
Arteriosclerosis, Hypertension, Uremia	a:
Due to	b:
Due to	c:
Other Conditions	d:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Halsey Barker M. D.
Address 1020 St. Paul St. Date signed 10/24/47

VS 150

Dr. Halsey Barker X

G56326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G56326

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3001 St. Paul St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 St. Paul St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie F. Lewis

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Alfred Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/12/73

8. AGE: Years	Months	Days	If less than one day
74	3	11	hr. min.

9. Birthplace Ocean, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Alex W. Tenant
13. Birthplace Scotland

MOTHER
14. Maiden Name ----
15. Birthplace Md.

16 (a) Informant Dr. J. H. Northam
(b) Address 3001 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Windsor Mill Road

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 Oct 25 1947 (Date rec'd by Registrar) (b) Interring for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1947, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1947 to Oct 23 1947, and that I last saw h.m. alive on Oct 23 1947.

Immediate cause of death	Duration
Sub Dura Cerebral Hemorrage	2 days
Left Side Paralysis	
Due to Arterial Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Nil
Major findings of operation: —
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature Herbert E. Zepp M. D.
Address 3400 Windsor Ave. Date signed 10/24/47

VS 150

56327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58a

Registered 56327

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4804 Richard Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda N. Button

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Clarence H. Button

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1895

8. AGE: Years 52 | Months 11 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Phila. Pa.
(Town, county and state)

10. Usual Occupation Telephone Operator

11. Industry or business W. U. R.R.

FATHER
12. Name Henry Kirbahn
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Quast
15. Birthplace Germany

16 (a) Informant Clarence H. Button
(b) Address 4804 Richard Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1947, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1947 to Oct 24 1947, and that I last saw h.s. alive on Oct. 24 1947

Immediate cause of death	Duration
Hypertherma	
Due to cerebral hemorrhage	
Due to hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. C. Duvall Jr. M.D.
Address Redwood & Green Date signed Oct 29

X

656328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

238986 317

656328 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Wilcox St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN F. McBRIDE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/28/84

8. AGE: Years	Months	Days	If less than one day
63	4	25	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Painting

FATHER 12. Name John McBride

13. Birthplace Md

MOTHER 14. Maiden Name Sarah Reynolds

15. Birthplace Md

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10/27/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1317 St. Paul St

19 (a) OCT 25 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-23 1947 at 7 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1947 to Oct 23 1947 and that I last saw h[illegible]ive on Oct 23 1947.

Immediate cause of death	Duration
Dissecting Aneurysm of Aorta	
Due to Arteriosclerosis of Aorta	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Truman B. Stephens M. D.

Address Johns Hopkins Hosp. Date signed 10-24-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

656329 Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town BALTIMORE (6) Uverlea (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 E. ELM AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES M. BENSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife ODA M. BENSON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/9/99

8. AGE: Years	Months	Days	If less than one day
48	9	15	hr. min.

9. Birthplace BALTIMORE CO. (Town, county, and state)
10. Usual Occupation INSPECTOR - U.S. GOVT.
11. Industry or business

FATHER
12. Name Joshua E. Benson
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Katie Hayes
15. Birthplace Balto Co Md

16 (a) Informant Mrs. C. M. Benson
(b) Address 4 E. Elm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27 47 (month) (day) (year)
(c) Cemetery or crematory Jessup Meth.
Location Balto Co. Md.

18 (a) Funeral director Carnahan Funeral Home
(b) Address 7401 Belair Rd.

19 (a) OCT 25 1947 (Date rec'd by registrar) (b) Huntington Hillcrest Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 1947 at 7:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29/1947 to 10/24 1947, and that I last saw him alive on 10/24 1947

Immediate cause of death	Duration
PULMONARY EMBOLISM	
Due to CORONARY THROMBOSIS	
Due to ARTERIOSCLEROSIS	
Other Conditions DIABETES MELLITUS (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Houska M. D.
Address St. Joseph Hosp. Date signed 10/24/47

VS 150

94a

G56330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 107

Registered No. G56330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison St & Linden Ave

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Born

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Fullerton

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Shirley Marie Burton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 May 1947

8. AGE: Years	Months	Days	If less than one day
	5	19	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual Occupation ---

11. Industry or business

FATHER

12. Name Leroy J. Burton

13. Birthplace Balto. Co., Md.

MOTHER

14. Maiden Name Marie C. Schrenker

15. Birthplace Balto. Co., Md.

16 (a) Informant Mr. Leroy J. Burton

(b) Address 3927 Putty Hill Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/25/47 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home

(b) Address 7401 Belair Road

19 (a) OCT 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Oct 1947 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Oct 1947 to 24 Oct 1947, and that I last saw h[illegible] alive on 24 Oct 1947

Immediate cause of death Bronchopneumonia — Duration 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. Allan Spied M.D.

Address Md. Gen. Hosp. Date signed 24 Oct 47

C56331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C56331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Be sure to state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 N.Patterson Park Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 N.Patterson Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Lind

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Conrad Lind
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-1875

8. AGE: Years	Months	Days	If less than one day
72	0	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Mallon
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Dear
15. Birthplace Germany

16 (a) Informant Mrs. Ralph Hartman
(b) Address 1905 N.Patterson Pk.Ave.

17 (a) Burial (b) Date thereof 10-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave & Rose St.

18 (a) Funeral director Albert L Miller
(b) Address 1606 N.Chester Street

19 (a) OCT 25 1947 (b) [signature] Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1947, at 7.50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from January 14 1947 to October 23 1947, and that I last saw [illegible] alive on October 23 1947.

Immediate cause of death	Duration
Cardiac Dilatation	1 Day
Due to Cardiac Hypertensive Disease	5 Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Eisenberg M. D.
Address 2025 E North Ave Date signed 10-24-47

G56332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G56332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3510 Poole Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Poole Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Elizabeth Barnes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Richard L. Barnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26-1866

8. AGE: Years 81 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Edmondson
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha
15. Birthplace Maryland

16 (a) Informant John T. Barnes
(b) Address 3510 Poole Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27-1947 (month) (day, year)
(c) Cemetery or crematory Mt. Pleasant
Location Hamper, Carroll Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3731 Falls Road

19 OCT 25 1947 (Date rec'd by registrar) (b) Courtesy of Williams

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23- 1947, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1947 to Oct 27, 1947, and that I last saw h[illegible] alive on Oct 23, 1947

Immediate cause of death: Pneumonia — Duration
Due to: Coronary Thrombosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. Hession M. D.
Address 4037 Falls Rd. Date signed 10/25/47

656333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 656333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 N. Lenewood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 N. Longwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa A. Dyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	5	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Dyer
13. Birthplace Ireland

MOTHER
14. Maiden Name Brigid
15. Birthplace Ireland

16 (a) Informant Katherine Dyer
(b) Address 1804 N. Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 OCT 25 1947 (Date rec'd by registrar) (b) Filed by Wellington M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1947, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1947, to Oct 23 1947, and that I last saw h alive on Oct. 13 1947

Immediate cause of death	Duration
Acute Cardiac failure	
Due to Hypertension in Cardio Vascular disease	5 yrs.
Due to Intracerebral	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. E. Reeder M.D.
Address 2314 W. North Ave Date signed 10/27/47

G56334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G56334

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Argyle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Brown (Polar Bundy)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1921.

8. AGE: Years: 26 | Months: 5 | Days: 18 | If less than one day: hr. min.

9. Birthplace Northumberland Co., Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Arterin Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Rosa Carter
15. Birthplace Virginia

16 (a) Informant Rosa C. Johnson
(b) Address 614 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1947. (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 25 19[illegible] Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 1947, at 5:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1947 to 10/23 1947, and that I last saw her alive on 10/23 1947

Immediate cause of death	Duration
Acute pulmonary edema bilateral; shock	Acute
Due to Rheumatic C.V.D. Mitral Stenosis	Unknown
Due to Rt. heart hypertrophy dilatation	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rheumatic Heart Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Union Hosp. Date signed 10/23/47

VS 130

WAKEMAN

G56335 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G56335

CERTIFICATE OF DEATH 1312

1. **PLACE OF DEATH** Rd.

Registered No.

CITY OF BALTIMORE: (No. 6970 Old Harford St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. **FULL NAME** Alice Lee Wakeman

If U. S. Veteran specify WAR

(a) Residence: No. 6970 Old Harford Rd St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

6a. If married, widowed, or divorced RUSBAND of (or) WIFE of Joseph W. Wakeman

6. DATE OF BIRTH (month, day, year) Aug 25, 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	2	0	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Front Royal (State or country) Virginia

FATHER

13. NAME George W. Robinson

14. BIRTHPLACE (city or town) unknown (State or country) Virginia

MOTHER

15. MAIDEN NAME Elizabeth Andrews

16. BIRTHPLACE (city or town) unknown (State or country) Virginia

17. INFORMANT Hugh Wakeman
(Address) 6970 Old Harford Rd.

18. BURIAL, CREMATION, OR REMOVAL
Place Front Royal Date Oct 25, 1947

19. UNDERTAKER Raymond Nudd Jr
(Address) Front Royal Va.

20. OCT 25 1947 19 Lucretia Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 25, 1947

22. I HEREBY CERTIFY, That I attended deceased from March 8, 1947, to Oct 25, 1947

I last saw her alive on Oct 24, 1947 Death is said to have occurred on the date stated above, at 9 30 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerotic Heart Disease	
Hemiplegia arteriosclerosis	
Chronic nephritis	
Other contributory causes of importance	

Was an operation performed? no Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? — Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
no If so, specify

(Signed) George Dawson M. D.
(Address) 4808 Harford Rd.

Information should be carefully supplied. AGE should be stated in YEARS, MONTHS, DAYS. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

W 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

Registered No. 656336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Franklin Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANKLIN BURNS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Edith ??
15. Birthplace "

16 (a) Informant Bessie Wright
(b) Address 908 W. Franklin st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 OCT 25 1947 (b) Huntington West Virginia
(Date filed by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1947, at 12.50 M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M. M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl A Ryder M.D.
Medical Examiner.
Date signed

656337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. 656337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 S. Caroline St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Woodland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-8-24

8. AGE: Years: 22 | Months: 11 | Days: 14 | If less than one day: hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Robert Moore
13. Birthplace S.C.

MOTHER — 14. Maiden Name Mattie Kelly
15. Birthplace S.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26. 1947 (month) (day) (year)
(c) Cemetery or crematory Wynnsboro
Location Wynnsboro, S.C.

18 (a) Fuperal director Chas. E. Wilson
(b) Address 1005 Blantley ave

19 OCT 25 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1947 at 2 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1947 to Oct 22 1947 and that I last saw her alive on Oct 22 1947

Immediate cause of death Uremia — Duration 5 mos.

Due to Chronic Glomerulephritis

Due to Subacute Bacterial Endocarditis

Other Conditions Rheumatic Heart Dis. & Failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Grob M. D.
Address J N H Date signed 23 Oct 1947

G56338 B. Cert 4 92361 D. Calas

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

154 Registered No. G56338

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12Hrs .& 5Min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 16,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Haupt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/24/47

8. AGE: Years | Months | Days | If less than one day: 12 hr. 5 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name LeRoy Howard Haupt
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Elizabeth Ford
15. Birthplace Baltimore Maryland

16 (a) Informant Bon Secour. Hosp Records
(b) Address 2025 W. Fayette St.

17 (a) BURIAL (b) Date thereof 10 27 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location WOODLAWN, MD.

18 (a) Funeral director JOHN F. DEANY, Inc
(b) Address 715 LIGHT ST -30

19 (a) OCT 25 1947 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25-47 1947 7:20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death: Respiratory Failure — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George W. Fisher
Address Bon Secours Hosp Date signed Oct 25

G56339 BALTIMORE CITY HEALTH DEPARTMENT ✓ G56339
Registered No.

CERTIFICATE OF DEATH 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Windsor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3311 Dorchester Rd (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. North

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Louise M. North
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 12-1870

8. AGE: Years 77 Months 6 Days 11 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Salesman

FATHER
12. Name Sebastian North
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Louise M. North
(b) Address 3311 Dorchester Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mills Road

18 (a) Funeral director Chas. F. Burns & Son
(b) Address 118 W Mt Royal Ave

19 (a) (Date rec'd by registrar) (b) Burlington Williams Reg.

OCT 28 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1947, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10, 1947 to Oct 21 1947, and that I last saw him alive on Oct 21, 1947.

Immediate cause of death: Uremia
Due to: Arteriosclerotic Cardio-vascular
Due to: Renal disease
Other Conditions: Pagets disease of the bone
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation: —
of autopsy: —

Duration: 7 days / many years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Sullivan
Address 11 E. Chase St Date signed Oct 27 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G56340 ✓ G56340

Registered No.

CERTIFICATE OF DEATH

61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Co.
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Temberg Grove Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifford Quintal

3 (b) If veteran, name war →

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Vera Quintal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-3-89

8. AGE: Years	Months	Days	If less than one day
57	10	22	hr. min.

9. Birthplace Illinois?
(Town, county, and state)
10. Usual Occupation Farm Supervisor
11. Industry or business

FATHER
12. Name George Quintal
13. Birthplace ?

MOTHER
14. Maiden Name ~~Vera Quintal~~ ada Marsh
15. Birthplace

16 (a) Informant Mrs. John C. Beaty
(b) Address McDonogh, Md

17 (a) Burial (b) Date thereof Oct. 28 '47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm Berryman & Sons
(b) Address Reisterstown, Md.

19 (a) Oct 26 1947 Huntington Williams Asst
(Date rec'd by registrar)

Oct

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1947, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1947 to Oct. 25 1947, and that I last saw him alive on Oct. 25 1947.

Immediate cause of death	Duration
Myocardial Infarction.	
Due to Coronary Artery Arteriosclerosis	
Due to	
Other Conditions Diabetes Mellitus Pulmonary Infection	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theron D Stephens M. D.
Address Johns Hopkins Hosp Date signed 10-26-47

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G56341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 1947

✓ G56341 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Belle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4013 Belle Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Gorfinz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, ~~widowed~~, or divorced. married

6 (b) Name of ~~husband~~ or wife Yetta Gorfinz

(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 67 | Months — | Days — | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Salesman - Retired

11. Industry or business Tobacco Industry

FATHER
12. Name Sholom Gorfinz
13. Birthplace Russia

MOTHER
14. Maiden Name Shaba Shapiro
15. Birthplace Russia

16 (a) Informant Yetta Gorfinz
(b) Address 4013 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Rogers Ave

18 (a) Funeral director Funk Sons Inc
(b) Address 2100 Eutaw Pl

(a) ____ (b) ____
(Date rec'd by registrar) Huntington Wills, Registrar

OCT 26 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1947, at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Oct. 24 1947, and that I last saw him alive on Oct 24 1947.

Immediate cause of death Tuberculosis (Pulmonary). Diabetes and coronary disease — Duration

Due to

Due to

Other Conditions Coronary occlusion and pulmonary edema
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Kaden M. D.

Address 2306 Eutaw Pl Date signed 10-24-47

G56342

BALTIMORE CITY HEALTH DEPARTMENT ✓ G56342
Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1816 Longwell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Longwell Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isadore Milton Radesky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Insurance Salesman

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Anna Radesky
(b) Address 1816 Longwell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Lane

18 (a) Funeral director Jack Levin Inc
(b) Address 2800 Eutaw Place

19 (a) 1947 (Date rec'd by registrar) (b) Lloyd Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Oct 26 1947 at 3 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 to 10/24 1947, and that I last saw h wife alive on 10/24 1947.

Immediate cause of death: Acute Coronary Thrombosis — Duration 1 Hrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature
Address 320 Eutaw St Date signed 10/28/47 M. D.

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56343 TB. 33976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G56343 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 N. High St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Steinkamp

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27th 1885

8. AGE: Years 62 | Months 8 | Days 7 28 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business

FATHER
12. Name Frank Kamp
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Murphy
15. Birthplace Baltimore, Maryland

16 (a) Informant WALTER J STEINKAMP
(b) Address 4643 COLERNE RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/27/47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL CEM
Location EDMONSON AVE

18 (a) Funeral director Charles F. Evans & Son
(b) Address 118 W. MT. Royal AVE

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 28 1947

S 150

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH Oct 24th, 1947 19 at 8.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4th 1938 to Oct 24 1947, and that I last saw him alive on Oct 24 1947.

Immediate cause of death	Duration
Pulmonary Edema	days
Due to Cardiac insufficiency	days
Due to Arteriosclerotic Cardiovascular disease	years
Other Conditions Cerebral Arteriosclerosis, Bycardial infarction, old. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 10-25-47

X

G56344 B-C-H S-90825 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 176a G56344 Registered No.

Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Charles
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Bel Alton (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kelly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-6-47

8. AGE: Years	Months	Days	If less than one day
3 wks.	-	18	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Kelly
FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Madeline Kelly
MOTHER 15. Birthplace Maryland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 10/27/47 (month) (day) (year)
(c) Cemetery or crematory Bel Alton
Location Charles County Md.

18 (a) Funeral director Geo. D. Nelson
(b) Address 1303 Presstman St.

19 (a) (b) (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1947 at 3:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1947 to Oct-24 1947 and that I last saw him alive on Oct-24 1947

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	
Due to INTRA-CRANIAL HEMORRHAGE	
Due to PREMATURITY	
Other Conditions Mother had DIABETES MELLITUS (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William A. Spencer M.D.
Address Johns Hopkins Date signed Oct 24 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure age is especially important. Physicians: please write

Margaret Harriet Kane

G56345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56345

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Sloven (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 Baird Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: MICHAEL POZNIKO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1923

8. AGE: Years	Months	Days	If less than one day
24	-	7	hr. min.

9. Birthplace Sloven, Pa. (Town, county, and state)

10. Usual Occupation Carpenters Helper

11. Industry or business

FATHER
12. Name George Poznika
13. Birthplace Pa.

MOTHER
14. Maiden Name Irene Dorohow
15. Birthplace Russia

16 (a) Informant Mrs Stella Fuller
(b) Address 329 Baird St. Sloven, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 26 1947 (month) (day) (year)
(c) Cemetery or crematory Fairview
Location Sloven, Pa.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk, Md.

19 (a) (Date rec'd) 1947 (Registrar) Lawrence Williams M.D. Registrar

OCT 28 1947 Va 451

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1947, at 7.45 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and died in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of Skull &
Internal Cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-24-47 at 11 p. M.
(b) Where did injury occur? Rt.#40-vicinity Otter Pt. 2 miles Edgemere inner section- Maryland.
(c) Did injury occur at home, on farm, industrial place, in public place? Yes While at work? No
(d) Means of injury Driver- auto overturned.

23. Signature [signature] M.D. Medical Examiner

Date signed 10-25-47

656346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

656346 Registered No. 516

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount Av
(c) Hospital or institution:
Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6710 Bessemer Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Biagio Guido

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Susie Guido
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 188[illegible]

8. AGE: Years 65 | Months 3 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name grabel guido
13. Birthplace Italy

MOTHER
14. Maiden Name Theresa Rizza
15. Birthplace Italy

16 (a) Informant Mrs Theresa Colonna
(b) Address 217 S Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27, 1947 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Germany Hill Road

18 (a) Funeral director Roland L. Fyffer
(b) Address 2112 Dundalk Ave.

19 (a) [illegible] (Signature of registrar) Registrar
(Date filed by registrar) OCT 28 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23- 1947 at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1947 to 10-23 1947 and that I last saw h.im alive on 10-22- 1947.

Immediate cause of death Bronchopneumonia — Duration
Cerebral Hemorrhage
(Antecedence of)
Due to Hypertension
Due to Pyelonephritis
Other Conditions Uremia
Adeno Carcinoma of Prostate
(Include pregnancy within 3 months of death)
Date of operation 10-10-47
Major findings of operation: Adeno Ca of Prostate
Adenocarcinoma of Prostate
Findings of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kirk Moore M.D. M. D.
Address Church Home + Hosp Date signed 10-27-47

VS - 150

X

G56347 ✓ G56347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Ridgley St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT R CRAWFORD ALIAS JOHN R. CRAWFORD ST.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6 1896

8. AGE: Years	Months	Days	If less than one day
51	0	16	hr. min.

9. Birthplace Arlington, Howe Iowa (Town, county, and state)
10. Usual Occupation Sales Supervisor
11. Industry or business Hirook Ginger Ale Co.

FATHER
12. Name John S. Crawford
13. Birthplace Arlington, Iowa

MOTHER
14. Maiden Name Grace P. Horton
15. Birthplace Iowa

16 (a) Informant John N. Crawford
(b) Address Chadbourne, N.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/26/47 (month) (day) (year)
(c) Cemetery or crematory Chadbourn, N.C.
Location Chadbourn, N.C.

18 (a) Funeral director Williams Lord Jones
(b) Address 1319 E. Pratt St

19 (a) 1947 (b) Received by registrar Arlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1947, at 9.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner
Date signed 10-22-47

VS 131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Oct 26 1947

G56348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. G56348

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Green Sts
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days): 6
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Pr. Geo.
(c) City or town: Bowie
(If outside city or town limits, write RURAL and give town)
(d) Street No.:
(If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

3 (a) FULL NAME: Harry Higgs

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife: Adel Higgs

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 15, 1869

8. AGE: Years	Months	Days	If less than one day
78	3	11	hr. min.

9. Birthplace: Charles Co. Maryland
(town, county, and state)

10. Usual Occupation: Farmer

11. Industry or business:

FATHER 12. Name: James Higgs
13. Birthplace: Charles Co. Md

MOTHER 14. Maiden Name: Alice Wells
15. Birthplace: Charles Co. Md

16 (a) Informant: Mrs. Spencer Higgs
(b) Address: Bowie, Maryland Rt 1

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 29/47 (month) (day) (year)

(c) Cemetery or crematory: Hyattsville
Location:

18 (a) Funeral director: Virginia Gaschy Sons
(b) Address: Hyattsville Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williamson M.D.

OCT 29 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/26 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1947 to 10/26 1947, and that I last saw him alive on 10/27 1947.

Immediate cause of death	Duration
Coll apse.	
Due to Gen. Debility.	
Due to Incarcerated Femoral Hernia.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: 10/20

Major findings of operation: Incarcerated Femoral Hernia,

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?: While at work?:
(Specify type of place)
(e) Means of injury:

23. Signature: H N Taylor M. D.

Address: Bowie Md Date signed: 10/29/47

VS 150

656349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 656349

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Genl Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days) RURAL

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A.
(c) City or town RURAL Irondale Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wellham Ave. Extension
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer P. Wenaker

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-03-3138

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Affelt
6 (c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.) June 23 1892

8. AGE: Years 55 | Months 4 | Days 1 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Typesetter

11. Industry or business: Printing

FATHER
12. Name: Peter Wenaker
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Elizabeth Deitzel
15. Birthplace: Baltimore Md

16 (a) Informant: Wife
(b) Address: Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 1947 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: 3801 Frederick Road

18 (a) Funeral director: Mrs. Mrs. John W. Leutz & Son
(b) Address: 534 Edmondson Ave

19 (a) OCT 21 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24 1947 at 9 23 A.M.

21. I certify that death occurred on the date above stated: that I attended deceased from 10-9- 1947 to 10-22-1947 and that I last saw h[illegible] alive on 10-22-1947.

Immediate cause of death: Arteriosclerotic cardiovascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard J. McElroy, M.D.

Address 211 Light St Date signed 10-27-47

VS 150

G56350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

+ 93 ✓

Registered No. G56350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 Maple av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Strine — Edward R. Strine

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-8312

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Anna L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1. 1899

8. AGE: Years 47 | Months 10 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation Supt. in bakery.

11. Industry or business Bakery

FATHER
12. Name John L.
13. Birthplace Penna

MOTHER
14. Maiden Name Mary Reinecke
15. Birthplace Penna

16 (a) Informant Mrs. Anna L. Strine
(b) Address 1233 Maple Ave. Arbutus

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Tuttle
(b) Address 4101 Edmondson Ave

19 OCT 27 1947 (Date rec'd by registrar) (b) Turntine for Nottingham, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1947, at 1.25 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1947 to 10-25 1947 and that I last saw h/M alive on 10-25 1947

Immediate cause of death Acute pulmonary edema — Duration

Due to rheumatic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Calvin B. Hearne M. D.
Address University Hosp. Date signed 10-25-47

VS 150

G56351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No. G56351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2504~~ Mercy Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Fuller J. Thornton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1888

8. AGE: Years 59 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Balto Maryland (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Patrick Thornton
13. Birthplace unknown

MOTHER 14. Maiden Name Mary Fuller
15. Birthplace unknown

16 (a) Informant Hosp record and daughter
(b) Address Mrs. Mary E. Mickinson 3514 Eidman

17 (a) Oct 28/47 (Burial, cremation, or removal) (b) Date thereof Buried (month) (day) (year)
(c) Cemetery or crematory Our Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry H. Fitzke
(b) Address 4101 Edmondson Ave

19 (a) Oct 27 1947 (Registered by registrar) (b) Hunting for Williams M.M.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1947 at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1947 to Oct 24 1947 and that I last saw him alive on Oct 24 1947.

Immediate cause of death	Duration
resp. failure	6 mos
Due to uremia	
Due to starvation	
Other Conditions carcinoma of esophagus	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: carcinoma esophagus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Peaty M.D.
Address Mercy Hosp. Date signed Oct 24 47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. 656352

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5943 Karon Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 5943 Karon ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Johannah M. Thomas

3 (b) If veteran, name war: —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Casper C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13, 1885

8. AGE: Years	Months	Days	If less than one day
62	1	11	hr. min.

9. Birthplace Baltimor Md (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name John Forster
13. Birthplace Md.

MOTHER
14. Maiden Name Anna King
15. Birthplace Md

16 (a) Informant Mr. Casper C. Thomas
(b) Address 5943 Karon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location 3210 Taylor Ave.

18 (a) Funeral director Harry N. Wilkes
(b) Address 4016 Edmondson Ave

19 (a) OCT 27 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1947 at 6:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1947 to Oct 24 1947 and that I last saw h alive on Oct 24 1947.

	Interval between onset and death
Immediate cause of death Cardiac Decompensation	
Chronic passive Pulmonary congestion - Cardiac Arthritis	3 yrs
Due to Bronchial Asthma	5 yrs
Due to	
Other Conditions Enormous ventral hernia at umbilicus. Obese	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno. Cliff
Address 5010 Greenleaf Road Date signed 10-25-47 (M. D.)

X

G56353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56353 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1557 Carswell st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wilbur Claude Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Daisy Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13th 1886

8. AGE: Years	Months	Days	If less than one day
61	2	12	hr. min.

9. Birthplace Annapolis Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Church Home & Hospital

FATHER
12. Name John Brown
13. Birthplace Annapolis Md.

MOTHER
14. Maiden Name Louise Hambrock
15. Birthplace Germany

16 (a) Informant Daisy Brown
(b) Address 1557 Carswell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff
Location Annapolis Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 27 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25th 1947, at 12 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to Oct 25 1947, and that I last saw him alive on Oct 25 1947.

Immediate cause of death: Myocardial Infarction — Duration 4 hrs.
Due to Arteriosclerotic Heart Disease — 7
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Arthur H. Seabrey M. D.
Address Medical Arts Bldg Date signed Oct 25 1947

VS 150

656354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G56354 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 Highwood Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Highwood Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Sekyra

3 (b) If veteran, name war —
3 (c) Social Security Account No. 217-24-9625

4 Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Monna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26. 1909

8. AGE: Years 38 Months 5 Days 1 If less than one day hr. min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Draftsman
11. Industry or business Gas & Coke

FATHER
12. Name Walter Sekyra
13. Birthplace Baltimore Md

MOTHER
14. Maiden name Hermina Herbst
15. Birthplace Baltimore Md

16 (a) Informant Monna Sekyra
(b) Address 705 Highwood Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Fuhrman Gorsuch Inc
(b) Address 1219 E Fort Ave

19 (a) OCT 27 1947 (Date rec'd by registrar) Huntington Willis (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1947, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 1947, to October 1947, and that I last saw h.e alive on October 24 1947.

Immediate cause of death: Carcinomatosis, abdominal — Duration 2 mos

Due to Carcinoma, transverse colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July, 1947

Major findings of operation: Malignant tumor transverse colon, metastases to liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Frederick J. Vollmer, M. D.
Address 6100 York Road Date signed Oct 27 1947

VS 150

G56355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G56355 Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 251 S. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 251 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ameling

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 1st 1874

8. AGE: Years	Months	Days	If less than one day
73	5	23	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Henry Amelung
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Wagner
15. Birthplace Balto Md

16 (a) Informant Wm Backert
(b) Address 1836 Gough St

17 (a) Burial (b) Date thereof 10/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Jr.
(b) Address 1217 St. Paul St

19 (a) Oct 27 1947 (Date received by registrar) Cremation for Williamsport Md

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Oct 24th 1947, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1947 Oct 24 1947, and that I last saw him alive on Oct 24 1947.

Immediate cause of death	Duration
Lobar Pneumonia	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton L. Solomon M. D.
Address 129 S. Broadway Date signed 10/25/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Register 056356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 Toone St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Toone St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas C. Lidard.

3 (b) If veteran, name war	3 (c) Social Security Account No.
**	**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Wido wed.

6 (b) Name of husband or wife Margaret Lidard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22nd. 1876

8. AGE: Years	Months	Days	If less than one day
70	71 10	2	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)
10. Usual Occupation Lunch Room
11. Industry or business

FATHER
12. Name James Lidard.
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Emma Mason.
15. Birthplace Baltimore, Md

16 (a) Informant Thomas C. Lidard Jr.
(b) Address 3506 Toone. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28th. 47 (month) (day) (year)
(c) Cemetery or crematory Catherdral
Location Frederick Ave.
18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811. N. Wolfe St.

19 OCT 27 1947 (Date rec'd by Registrar) (b) Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24th. 1947 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1947 to Oct. 24 1947 and that I last saw h.(M) alive on Oct. 24 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Tenney M. D.
Address 441 N. Eden St. Date signed 10/25/47

X

G56357 B.C. 4-99149 G56357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V160c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 24
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Hull St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Swirdowich SWIRDOWICK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	0	0	0 hr. 10 min.

9. Birthplace Baltimore, Maryland (Town, county, and State)
10. Usual Occupation 0
11. Industry or business

FATHER
12. Name Walter Swirdowich
13. Birthplace Troy, New York

MOTHER
14. Maiden Name Mildred Holder
15. Birthplace Bath, Md.

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Martin V. Offutt Sons.
(b) Address Lombard & Arlington Sts.

OCT 27 1947 (Date received by Registrar) (b) Huntington Williams M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1947 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 19 to 10/25 19, and that I last saw him alive on 10/25/47 19

Immediate cause of death	Duration
Asphyxiation, failure	
Due to cord 2x around neck & long labor.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Nitzke
Address University Hosp. Date signed 10/26/47

G56358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56358

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st Sts
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Glenam
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
George Walter Haymen

3 (b) If veteran, name war: WW 2

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosa Harris Haymen

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 3, 1908

8. AGE: Years 39 | Months 5 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business VETERAN

FATHER
12. Name Wm Haymen
13. Birthplace Eastern Shore--- Md

MOTHER
14. Maiden Name Mary Stevens
15. Birthplace Annapolis, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29-47 (month) (day) (year)
(c) Cemetery or crematory Fairview
Location Forest Hill MD

18 (a) Funeral director Howard L. Macklin
(b) Address Wheaton Md

19 (a) Oct 27 1947 (b) Huntington Williams, M.D.
(Filed by registrar) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1947, 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1947 to Oct. 25 1947, and that I last saw him alive on Oct. 25 1947

Immediate cause of death: Carcinoma of rectum with extension to pelvis and regional lymph nodes, metastases to lungs and liver (postoperative state Due to colostomy) emaciation — Duration: 10 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. P. van Antwerp, Medical Director U.S.P.H.S.
Address Medical Officer in Charge Signed 10/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

56359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G56359 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 Old Orchard Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Old Orchard Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wells Alexander

3 (b) If veteran, name war: ---

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eudora D. Alexander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1871

8. AGE: Years 76 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Charles A. Alexander
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Annie B. Wells
15. Birthplace Pa.

16 (a) Informant Mrs. Eudora D. Alexander
(b) Address 509 Old Orchard Rd.,

17 (a) Burial (b) Date thereof 10-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

OCT 27 1947 Baltimore, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 1.30

20. DATE OF DEATH October 25, 1947, at A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Oct 25 1947 and that I last saw alive on Sept 7 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 1/2 hr.

Due to: Cardio-Vas Renal Disease — 4 1/2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. P. Van Schaick, M. D.
Address 618 E. Lanvale Date Oct 27, 1947

VS 150

656360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 656360

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 10, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 4822 Roland Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Dr. M. Gibson Porter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1865

8. AGE: Years	Months	Days	If less than one day
82	0	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business —

FATHER
12. Name G. Ellis Porter
13. Birthplace Maryland

MOTHER
14. Maiden Name Alcinda Gibson
15. Birthplace Maryland

16 (a) Informant Miss Margaretta Porter
(b) Address 4822 Roland Ave City 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/47 (month) (day) (year)
(c) Cemetery or crematory
Location Frostburg, Md.

18 (a) Funeral director John H. Meitzler & Sons, Inc.
(b) Address 1700 Eutaw Place

19 Oct 27 1947 Howard J. Willemus, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1947, at 11:07 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 16 1947 to October 25 1947 and that I last saw h... alive on Oct 25 1947.

Immediate cause of death	Duration
Terminal bronchopneumonia	8 days
Due to Fracture r.t. hip	9 days
Due to	
Other Conditions Diabetes, Arteriosclerosis (Include pregnancy within 3 months of death)	—

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following. 27/14
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 10/16/47 at 7 A.M.
(c) Where did injury occur? at home - Balto., Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home (Specify type of place) While at work? No
(e) Means of injury fall on floor

23. Signature John K. Lattimer, Jr. M.D.
Address Union Memorial Hospital Date signed 10/25/47

Howard J. Willemus, M.D.

056361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 056361

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA EISENSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Allen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Ruth (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Aaron Ruth
13. Birthplace

MOTHER
14. Maiden Name Dora Ruth
15. Birthplace

16 (a) Informant Harry Katz
(b) Address 106 E. Market Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-47 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) OCT 27 1947 (Date Rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26/1947, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1947 to 10-26 1947, and that I last saw her alive on 10-26 1947.

Immediate cause of death Cerebral Embolism Due to Arteriosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert Grubman, M.D.
Address 3107 N. Wath Ave Date signed 10/26/47

G56362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No. G56362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST.
(c) Hospital or institution: St. JOSEPH'S HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County B
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 McELDERRY ST.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HARDESTY, Ruby

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Patrick Hardesty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/20/23

8. AGE: Years	Months	Days	If less than one day
24	7	4	hr. min.

9. Birthplace KENTUCKY (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name Kinney Carpenter
13. Birthplace Kentucky

MOTHER
14. Maiden Name Sarah Gibbs
15. Birthplace Kentucky

16 (a) Informant Patrick Hardesty
(b) Address 2218 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27 1947 (month) (day) (year)
(c) Cemetery or crematory Carpenter
Location Jakeboy, Breathitt Co. Kentucky

18 (a) Funeral director John A. Miller
(b) Address 2254 Jefferson St.

19 (a) OCT 27 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1947, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1947, to 10/25 1947 and that I last saw [illegible] alive on 10/25 1947

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to CONGESTIVE HEART FAILURE	
Due to ACUTE GLOMERULO-NEPHRITIS	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy ANASARCA, CPC Chart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry P. Porter M.D.
Address [illegible] Date signed 10/25/47

G56363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G56363

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Mohawk Ave
(c) Hospital or institution:
Anderson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Gilman Apts. Calvert & 31st.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH KENT HILL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laeva C. Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/87

8. AGE: Years	Months	Days	If less than one day
73	2	11	hr. min.

9. Birthplace Prince George Co. Maryland
(Town, county, and state)
10. Usual Occupation Ticket Agent
11. Industry or business Par-Mutual Racing Co.

FATHER
12. Name Dr. Melvin F. Hill
13. Birthplace Prince George Co. Md.

MOTHER
14. Maiden Name Carolyn Roberts
15. Birthplace Prince George Co. Md.

16 (a) Informant Mrs Joseph K. Hill
(b) Address Gilman Apts-Calvert & 31st

17 (a) Burial (b) Date thereof 10/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. H. Myers and Son
(b) Address 805 N. Calvert St.

19 Oct 27 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26, 1947, at 12:16 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1947 to Oct 26 1947, and that I last saw him alive on Oct 25 1947.

Immediate cause of death	Duration
Myocardial Failure	10 days
Due to Coronary artery sclerosis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury
23. Signature Frances W. Stuck
Address 3406 St Paul St Date signed M. 10 D. 27/47

G56364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56364

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days): DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1825 East Baltimore Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: SAMUEL MEDWICK (Sam Medrick) MEDRICK

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 205-09-0133

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1893

8. AGE: Years: 54 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Labor

11. Industry or business

FATHER
12. Name: Roman Medrick
13. Birthplace: Russia

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Joseph Maloff
(b) Address: 1825 E Baltimore St

17 (a): Burial (Burial, cremation, or removal) (b) Date thereof: 10-27-47 (month) (day) (year)
(c) Cemetery or crematory: Sacred H. of Mary
Location: Balto Co.

18 (a) Funeral director: J Bruce Lemmon
(b) Address: 1449 Eastern Ave Rd

19 (a): OCT 27 1947 (Date rec'd by registrar) (b): Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/25/47 19 , at 11:16 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: John Rhein M.D. Medical Examiner.
Date signed: 10/27/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56365

~~36365~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 S. Smallwood St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Samuel H. Fish (SAMUEL H. FISH)

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary A. Fisk
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1878

8. AGE: Years 69 | Months 7 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Foreman
11. Industry or business Victor Bloede Co.

FATHER 12. Name Robt. C. Fish
13. Birthplace Maryland

MOTHER 14. Maiden Name Eliza Wolfe
15. Birthplace Maryland

16 (a) Informant Mary A. Fisk
(b) Address 319 S. Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. D. Raphael & Son
(b) Address 320 Eutaw Place

19 OCT 27 1947 (Date rec'd by registrar) (b) Huntington Wilson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1947 at 10:50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1947 to Oct 22 1947 and that I last saw him alive on Oct 22 1947

Immediate cause of death: Cerebral hemorrhage — Duration: ____
Due to: Hypertension CVD. — ____
Due to: ____ — ____
Other Conditions: Terminal Pneumonia. — ____
(Include pregnancy within 3 months of death) — ____
Date of operation: none — ____
Major findings of operation: ____ — ____
of autopsy: none — ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hubert J. Luecke M.D.
Address St. Agnes Hosp. Date signed 10/27/47

G56366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G56366

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31 St & Wyman Pk. Dr.
(c) Hospital or institution:
U. S. Marine Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52y 10m 28d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2340 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Shew, William Brent, Sr. (William Brent Shew, Sr.)

3 (b) If veteran, name war: Vet World 1
3 (c) Social Security Account No. 217-14-5391

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth Wollett Shew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30, 1895

8. AGE: Years 51 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation clerk

11. Industry or business

FATHER
12. Name Harry F. Shew, Sr
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Eunice Brent
15. Birthplace Balto., Md.

16 (a) Informant Hospital Records
(b) Address US Marine Hospital, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 28-1947 (month) (day) (year)
(c) Cemetery [redacted] Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna Aves.

19 (a) OCT 27 1947 (Date rec'd by registrar) (Huntington Williams M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1947 at 12:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1947 to Oct. 25 1947, and that I last saw him alive on 10-25-1947.

Immediate cause of death: Leukemia — Duration:

Due to:

Due to: Leukemia

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Freburtstall, M.D. M. D.
Address U. S. Marine Hosp. Date signed 10-27-47

VS 150

X

656367

285-761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 656367

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 230 Bethel Court. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Fletcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Earl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 33 | Months | Days | If less than one day hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace S.C.

MOTHER
14. Maiden Name ? ?
15. Birthplace S.C.

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 47 (month) (day) (year)
(c) Cemetery or crematory Balto National Cem.
Location A. A. County

18 (a) Funeral director Mrs Robt A. Ellicott Dept
(b) Address 1129 N. Caroline St

19 (a) Oct 27 1947 Huntington Williams, M.D. (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 23 - 1947, at 7 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Oct 1947 to 23 Oct 1947 and that I last saw h-H alive on 23 Oct 1947

Immediate cause of death Subarachnoid Hemorrhage — Duration 2 to 5 days

Due to ? aneurysm of cerebral artery

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Subarachnoid Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Grob

Address J H H Date signed 28 Oct 47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7705 Meath Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Enoch Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/14/04

8. AGE: Years 43 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Bridgeville, Pa.
(Town, county, and state)

10. Usual Occupation Wife

11. Industry or business

FATHER
12. Name John Burns
13. Birthplace Ireland

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Enoch Mitchell
(b) Address 7705 Meath Rd

17 (a) Removal (b) Date thereof 10/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Johns Cemetery
Location Long Island City N.Y.

18 (a) Funeral director Roland L. Fisher
(b) Address 2117 Dundalk Ave

19 (a) OCT 27 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 19 47, at 7 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 19 47 to 10-26 19 47 and that I last saw her alive on 10-26 19 47

Immediate cause of death	Duration
Uremia	
Due to Chronic glomerular nephritis	
Due to	
Other Conditions Congestive heart failure	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address St. Joseph's Hosp Date signed 10-26-47

X

B.C.H.D. 9-91887

G56369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G56369

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: So. Balti. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days) 12 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Angelina Bellisimo
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/14/47

8. AGE: Years	Months	Days	If less than one day
		12	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Charles D. Bellisimo
13. Birthplace Caldwell W. Va.

MOTHER
14. Maiden Name Nellie Sturnk
15. Birthplace Louisville Kentucky

16 (a) Informant Father - Charles Bellisimo
(b) Address 1809 St Paul St.

17 (a) Burial (b) Date thereof 10/27-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd + Moravia Rd
18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Motley St.
19 OCT 27 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1947, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1947 to 10/26 1947 and that I last saw her alive on 10/26 1947.

	Duration
Immediate cause of death Respiratory failure	22 min.
Due to Prematurity 32 wk pregnancy wt 3 lb 14 oz	12 da.
Due to	
Other Conditions Diarrhea	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. W. Cooper M.D.
Address 2159 Mt Holly St Date signed 10/26/47

VS 150

656370

CM. 112995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 656370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days) 22 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 725 Walsche ST. Waesche H
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Margaret Tutt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22- 1920

8. AGE: Years	Months	Days	If less than one day
27	8	4	hr. min.

9. Birthplace Fla.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Willie Tutt
13. Birthplace GA.

MOTHER
14. Maiden Name Gertrude Cable
15. Birthplace FLA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Oct 29, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave

19 (c) 1947 (d) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 - 1947; at 2.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14-47 19 47 to 10-26 - 1947, and that I last saw her alive on Oct. 26 - 1947

	Duration
Immediate cause of death Tuberculosis, pulmonary, bilateral far-advanced with cavitation	5 mos.
Due to	
Due to Tuberculosis of spleen, liver & kidneys. Tuberculous enteritis.	?
Other Conditions Cachexia, Malnutrition Acute miliary tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M.D. M. D.
Address Baltimore City Hosp. Date signed 10-26-47

VS 150

G56371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G56371
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: D.O.A.
(c) Hospital or institution: Providence Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bessie Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 66 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poolesville Md.
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Perry Hayes
13. Birthplace Md.

MOTHER
14. Maiden Name Jane
15. Birthplace Md.

16 (a) Informant Roger Halloran
(b) Address Cadwalader Md.

17 (a) Burial (b) Date thereof Oct 29 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Cemetery
Location Poolesville, Md.

18 (a) Funeral director C. H. Dawson
(b) Address Poolesville Md.

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

OCT 27 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1947, at 7:25 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Pelouze M.D.
Medical Examiner.
Date signed 10/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G56372 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 N. Broadway
(c) Hospital or institution:
8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE ALMAR AULD

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Harry W. Auld
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1882

8. AGE: Years	Months	Days	If less than one day
65	3	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Dailey
13. Birthplace Norway

MOTHER
14. Maiden Name Minnie A. ?
15. Birthplace Germany

16 (a) Informant Mrs. Mary T. Moreland
(b) Address 1613 N. Broadway

17 (a) Burial (b) Date thereof 10/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.
18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY
19 (a) Thos. Bruzton Williams, M.D. Registrar
(Date received by registrar)
OCT 27 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 24, 1947 19 , at 12.01 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 24 1947 to October 24 1947, and that I last saw h[illegible] alive on October 24 1947.

Immediate cause of death	Duration
Cerebral Apoplexy	4 hrs.
Due to Arteria-Sclerotica Hypertension	15 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Sandler M.D.
M. D.
Address 176 E. Fayette St Date signed 10/28/47

X

D56373

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

G56373
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.2+
(b) Street address
(c) Hospital or institution: South Balt. General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore P.F. 3
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2134 Annapolis Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Magdeline Turner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Andrew Turner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1889

8. AGE: Years	Months	Days	If less than one day
58	2	0	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired Nurse
11. Industry or business

FATHER
12. Name John Schmeissen
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Doerfler
15. Birthplace Germany

16 (a) Informant John Turner
(b) Address Finksburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28-47 (month) (day) (year)
(c) Cemetery or crematory Laurel Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 3512 Frederick Ave.

19 (a) (Date received by registrar) (Registrar)

OCT 27 1947

VS. 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1947, at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C.V. disease

Due to

Other Conditions Bronchial asthma

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. P. Schwab M.D.
Medical Examiner.
Date signed 10/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56374 BALTIMORE CITY HEALTH DEPARTMENT G56374

CERTIFICATE OF DEATH 1937

Registered No.

Every item of information should be carefully supplied. Use correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1742 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL P. PRZYNSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Stella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/6

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Florist

11. Industry or business For Self

FATHER
12. Name Przynski
13. Birthplace Poland

MOTHER
14. Maiden Name Lenny
15. Birthplace Poland

16 (a) Informant Stella Przynski
(b) Address 1742 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave

19 (a) Oct 27 1947 (Date rec'd by registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23/47, at 5:45 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury , at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 10/24/47

G56375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G56375

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Rydzynski
3 (b) If veteran, name war
3 (c) Social Security Account No. 215 28 8139

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male.	White	Married

6 (b) Name of husband or wife Joanna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Fire Dept.

FATHER
12. Name John Rydzynski
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Joanna Rydzynski
(b) Address 321 S Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29 (month) (day) 47 (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1936 Fleet [illegible]

1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26- 1947, at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1947 to Oct 26 1947, and that I last saw him alive on Oct 26 1947

Immediate cause of death	Duration
Asthenia d/t intestinal obstruction	
Due to Post-operative to intestinal	
Due to obstruction + resection of bowel (ascending colon)	
Other Conditions Carcinoma of bowel	

(Include pregnancy within 3 months of death)

Date of operation 10-15-47
Major findings of operation: Obstruction of bowel by carcinoma.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert M. Carouge M.D.
Address 6226 Enrolle Ave. Date signed 10/26 M. D.

VS 150

X

G56376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56376

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Hubbard St. (If rural give location)
(e) Citizen of foreign country? Haiti (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Flynn

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Anna E. Flynn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19-

8. AGE: Years	Months	Days	If less than one day
64	2	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Davidson Chem. Co.

FATHER
12. Name John Flynn
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary A. Gibbins
15. Birthplace Ireland

16 (a) Informant Miss Helen Flynn
(b) Address 1307 Hubbard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn - Fleming
(b) Address 1426 Light St.

1947 OCT 27 1947 Huntington Williams M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24 1947, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1947, to 10-24 1947 and that I last saw him alive on 10-24 1947.

Immediate cause of death	Duration
Arteriosclerotic heart disease and pneumonia	
Due to infarct, R&L lung	
Due to Rt. R. femoral phlebitis	
Other Conditions Thrombophlebitis Renal insufficiency	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Pneumonia, infarct R&L

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Nesy M. D.
Address St. Jos. Hosp Date signed 10-28-47

VS 150

G56377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G56877

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3433 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3433 Falls Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E Law

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John D. Law

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 - 1867

8. AGE: Years 80 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Leo P. Nace
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Unknown
15. Birthplace Pennsylvania

16 (a) Informant John D. Law
(b) Address 3433 Falls Road

17 (a) Burial (b) Date thereof Oct. 29-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Hanover Pennsylvania

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

OCT 27 1947
(Date rec'd by registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1947, at 7 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelbrick M.D.
Medical Examiner.
Date signed Oct 26, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 656378

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4206 Stanwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Stanwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Sullivan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced,
Male	White	Marr[illegible]

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2-1894

8. AGE: Years	Months	Days	If less than one day
53	2	22	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Produce Dealer
11. Industry or business

FATHER
12. Name Joseph Sullivan
13. Birthplace Md

MOTHER
14. Maiden Name Annie Offendefer
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Sullivan
(b) Address 4206 Stanwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28th 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 OCT 27 1947 (Date rec'd by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24th 1947, at 5:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1947 to Oct 24 1947 and that I last saw h[illegible] alive on Oct 24 1947.

Immediate cause of death Pulmonary Tuberculosis — Duration 2 1/2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 300 Pleasant Bldg Date signed Oct 27-47

VS 150

056379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

98

Registered No. 056379

CH. 114252

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 22 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Brooks

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Margaret (D.)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 24-1887

8. AGE: Years	Months	Days	If less than one day
60 Yrs.	-	1	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Brooks
13. Birthplace MD.

MOTHER
14. Maiden Name Katie Kilmer
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29th 1947 (month) (day) (year)
(c) Cemetery or crematory Marlands
Location Gaylor Ave

18 (a) Funeral director Lee G. Brooke
(b) Address 1701-03 N. Pattinson Park ave

19 (a) OCT 27 1947 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 - 1947, at 1.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10- 3- 1947 to 10-25 - 1947 and that I last saw h im alive on Oct. 23- 1947.

Immediate cause of death Bronchopneumonia — Duration 3 wks

Due to

Due to

Other Conditions arteriosclerosis, gangrene of left toe — 3 wks
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt. City Hosps Date signed 10/25/47

VS 150

656380 LYNDA BALTIMORE CITY HEALTH DEPARTMENT 48B Registered No. 656380

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Sheldon Rd
(c) Hospital or institution: 3520 Shriners Nervous Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore 27 (If outside city or town limits, write RURAL and give town)
(d) Street No. Arbutus (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lynda May Stroyock

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Clarence Stroyock
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) January 27 1921

8. AGE: Years	Months	Days	If less than one day
26 28	9	5 29	hr. min.

9. Birthplace: Stanley Va (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Farm Wife No. 60

FATHER
12. Name: Ezra Price
13. Birthplace: Stanley Va

MOTHER
14. Maiden Name: Vesta Bradley
15. Birthplace: Stanley Va

16 (a) Informant: Clarence T. Stroyock
(b) Address: Arbutus Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29th 1947 (month) (day) (year)
(c) Cemetery or crematory
Location: Linwood Va.

18 (a) Funeral director: Leo G. Leasch
(b) Address: 1901-03 N Patterson Park Ave

19 (a) OCT 27 1947 (Date rec'd by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1947 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1947 to Oct 26 1947, and that I last saw h.e alive on Oct 25 1947.

Immediate cause of death	Duration
Carcinoma Uterus	8 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: F F A Stevens M. D.
Address 2818 Harford Rd Date signed 10-27-47

X

G56381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital 7600
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give county)
(d) Street No. 5502 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E Beatty

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M.

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7-1890

8. AGE: Years	Months	Days	If less than one day
57	2	20	hr. min.

9. Birthplace Baltimore Md.
(town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business

FATHER
12. Name Beatty
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E. Tawney
15. Birthplace Md.

16 (a) Informant Mrs. Lena Beatty
(b) Address 5502 Harford Rd.

17 (a) Burial (b) Date thereof 10/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Morland Park.
Location Md.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) OCT 27 1947 (b) Huntsville for Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1947 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 10/27/47

VS 181

X

656382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 656382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1914 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie E. Nauman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Fred Nauman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1st 1893

8. AGE: Years	Months	Days	If less than one day
54	9	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Factory Worker
11. Industry or business Hat'l Store Fixtures Co.

FATHER
12. Name Patrick J. Gannon
13. Birthplace Ireland

MOTHER
14. Maiden Name Marie E. Carr
15. Birthplace Ireland

16 (a) Informant Thomas J. Gannon
(b) Address 3236 Cliftmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (a) [illegible] (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25th 1947 at 6a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1947 to Oct 25 1947. and that I last saw her alive on Oct 20 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to Menopausal Syndrome	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Martin, Jr. M. D.
Address 1933 W. Baltimore Date signed 10/27/47

056383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157M

Registered No. 056383

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 633 W. Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonino Battaglia

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20-1933

8. AGE: Years	Months	Days	If less than one day
14	2	5	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Battaglia
13. Birthplace Italy

MOTHER
14. Maiden Name Frandes alassio
15. Birthplace Italy

16 (a) Informant Joseph Battaglia
(b) Address 633 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Road

18 (a) Funeral director Joseph Fonaca Jno.
(b) Address 2013 Gleanmoran Ave

19 (a) OCT 27 1947 (Date rec'd by registrar) (b) Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1947 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17, 1947 to Oct. 25, 1947, and that I last saw him alive on Oct. 25, 1947.

Immediate cause of death	Duration
Acute Cardiac D'Latation.	12 days
Due to Amyotonia Congenita.	14 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ed Tommarelli M.D.
Address 711 Medical Arts Bldg. Date signed 10/27/47

G56384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 448

Registered No. G56384

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7/
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Country Colombia, South America
(c) City or town Bogota
(If outside city or town limits, write RURAL and give town)
(d) Street No. 76 th St 764
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Columbia S A.

3 (a) FULL NAME José J. Jaramillo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Julia Jaramillo
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/26/06

8. AGE: Years	Months	Days	If less than one day
41	9	0	hr. min.

9. Birthplace Bogota, Colombia, S. A.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Francisco Jaramillo
13. Birthplace Colombia, South America

MOTHER
14. Maiden Name Delores Arango
15. Birthplace Colombia, South America

16 (a) Informant Mr. C. Jaramillo
(b) Address Bogota, Colombia, S. A.

17 (a) Removal (b) Date thereof 10/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Bogota, Colombia, South America

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Oct 27 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

OCT 27 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1947, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1947 to 10/26 1947
and that I last saw him alive on 10/26 1947.

Immediate cause of death Hodgkins Disease — Duration 3 Mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Hodgkins Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury
23. Signature Huntington Williams, M.D.
Address 1 W. Mt. Royal Ave. Date signed 10-27-47

656385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 656385

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2938 Independence St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2938 Independence St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINA KAPPES HEILMANN

3 (b) If veteran, name war ------
3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Oswald Heilmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Joseph H. Kappes
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Braumwagel
15. Birthplace Germany

16 (a) Informant Mr. Oswald Heilmann
(b) Address 2938 Independence St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) OCT 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/47 19 , at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1947 to Oct 25 1947 and that I last saw her alive on Oct. 25 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	3 weeks
Due to Arteriosclerosis Cardio-Vascular Disease	?
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Walter H. Fuesting M. D.
Address 11 E. Chase St. Date signed 10-27-47

V S 190

G56386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G56386

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4104 Fifth ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mary Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife: Henry H. Elliott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-1-78

8. AGE: Years	Months	Days	If less than one day
69	1	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Fred Williams
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Kaine
15. Birthplace Germany

16 (a) Informant Henry H. Elliott - husband
(b) Address 4104 Fifth Ave. Brocklyn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/47 (month) (day) (year)
(c) Cemetery or crematory xxxxx Holy Redeemer
Location 4430 Belair Road, Balto. Md

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) OCT 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 October 1947, at 8 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1947 to 10-27 1947, and that I last saw her alive on 10-27 1947.

Immediate cause of death	Duration
diabetes	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-8-47

Major findings of operation: Chronic Cholecyst. Chilthiasis: Chr. Inflamation, pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank H. Krahl M.D.
Address Maryland Gen. Hosp. Date signed 10-27-47

B56387
186657

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

Registered No. 656387

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 E Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Carter.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	married

(b) Name of husband or wife Joseph Carter
(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Surles
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Rich
15. Birthplace Va.

16 (a) Informant records
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct 30. 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Brandywood

19 (a) OCT 27 1947 (Date rec'd by registrar) Certificate for Williamsburg Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1947, at 1 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11- 1947 to 10-26-1947 and that I last saw her alive on 10-26-1947

Immediate cause of death Epidermoid Carcinoma of Cervix. — Duration 18 months
Due to Extention of Cancer
Due to Hemorrhage — 3 weeks
Other Conditions -0-
(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation: —
of autopsy: not done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert P. O'Donnell M.D.
Address Johns Hopkins Hospital Baltimore Maryland. M. D. Date signed 10-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G56388

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) If hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sallie Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	Colored	Married

6 (b) Name of husband or wife Solomon Hill

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) July 17, 1900

8. AGE: Years	Months	Days	If less than one day
47	3	8	hr. min.

9. Birthplace Petersburg Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alexander Briggs
13. Birthplace Petersburg Va

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Petersburg Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Brantley Ave

19 (a) (Date received by Registrar) OCT (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 - 1947, at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Oct 1947 to 25 Oct 1947, and that I last saw h[er] alive on 25 Oct 1947.

Immediate cause of death: Diabetic coma — Duration: 1 day

Due to

Due to

Other Conditions: Aspiration of vomitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute aspiration of vomitus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Grob M. D.

Address J H H Date signed 25 Oct 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1278

Registered No. 056389

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 136 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5264 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Preston S. Snider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1882

8. AGE: Years	Months	Days	If less than one day
65	0	25	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name John Snyder
13. Birthplace Md

MOTHER
14. Maiden Name Sally Pickings
15. Birthplace Md.

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/47 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Cem
Location Elkridge, Md.

18 (a) Funeral director C. Vernon Lonaman
(b) Address 4611 Park Heights Ave.

19 (a) OCT 27 1947 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1947 at 5:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1947 to Oct. 24 1947, and that I last saw him alive on Oct. 24 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Generalized debility	
Due to Chronic gall bladder disease including gall bladder	
Other Conditions fistula	

(Include pregnancy within 3 months of death)
Date of operation 10-4-47; Chole-cholecystectomy;
Major findings of operation: 10-4-47; Chronic fistula; 10-5 left common bile duct
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Hunter, M.D.
Address Univ. Hosp. Date signed 10-24-47

VS 190

G56390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45a

Registered No. G56390

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 133 days
(e) Length of stay in Baltimore (yrs., mos., or days) 133 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Framingham
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? nav. (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Arthur Rietta

3 (b) If veteran, name war --
3 (c) Social Security Account No. 022-12-3609

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Wid
6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1868

8. AGE: Years 79 | Months 4 | Days 15 | If less than one day ____hr. ____min.

9. Birthplace Puerto Riva (Town, county, and state)
10. Usual Occupation Lt.
11. Industry or business Seafarer

FATHER
12. Name Arthur Rietta
13. Birthplace Puerto Riva

MOTHER
14. Maiden Name Clara ?
15. Birthplace Boston, Mass.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 1947 (month) (day) (year)
(c) Cemetery or crematory Edgelea Grove
Location Framingham Mass

18 (a) Funeral director A. Reiley Slade
(b) Address 4907 York Road

19 (a) (Date received by Registrar) (b) Registrar

OCT 31 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Oct. 28 1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1947, to Oct. 28 1947, and that I last saw him alive on Oct. 28 1947.

Immediate cause of death: Squamous cell carcinoma lower lip with recurrence with metastases to right side of face and neck and left submandibular lymph nodes

Duration: 32 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emerson Y. Gledhill
Emerson Y. Gledhill, Surgeon M.D.
Address US Marine Hospital Date signed 10/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56391 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G56394

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st Sts.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 32 days
(e) Length of stay in Baltimore (yrs., mos., or days): 32 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: NY (b) County:
(c) City or town: New York (If outside city or town limits, write RURAL and give town)
(d) Street No.: 335 W. 14th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: John Feben — Foben

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: 076-20-3633

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Wid.

6 (b) Name of husband or wife: Edith Robinson Foben

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1868

8. AGE: Years: 67 | Months: -- | Days: 8 | If less than one day: hr. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: Seafarer

FATHER
12. Name: Thomas Feben
13. Birthplace: Austria

MOTHER
14. Maiden Name: Katherine Martin
15. Birthplace: Austria

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 29 47 (month) (day) (year)
(c) Cemetery or crematory: St. Marys
Location: Livingston N.Y.

18 (a) Funeral director: Geo L. Berger Jr
(b) Address: 1512 Hollins St

19 (a) O[illegible] 1947 (Date rec'd by registrar) (b) [illegible]

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28, 1947, at 9:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1947 to Oct. 28 1947, and that I last saw h[illegible] alive on Oct. 28 1947

Immediate cause of death: Carcinoma, lung left, upper lobe with necrosis — Duration: 1 yr

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: aspiration biopsy

Major findings of operation: upper lobe 12/27/46

Microscopic Diag. anaplastic CA

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Clyde H. Dalton M. D.

Address: Date signed:

656392

656392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1820 W. Fayette Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 W. Fayette Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Willie J. Harman

3 (b) If veteran, name war: yes #1

3 (c) Social Security Account No. 232-24-0377

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Beulah V. Harman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1890

8. AGE: Years 57 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Harman, West Virginia (Town, county, and state)

10. Usual Occupation School Teacher

11. Industry or business

FATHER
12. Name Silom Harman
13. Birthplace West Virginia

MOTHER
14. Maiden Name Rebecca Mallow
15. Birthplace West Virginia

16 (a) Informant Cleda L. Harman
(b) Address 1820 W. Fayette Street

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 10/28/47 (month) (day) (year)
(c) Cemetery or crematory Davis Cemetery
Location Davis, West Virginia

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Oct 27 1947 (Date rec'd by registrar) (b) Huntington, West Virginia Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1947, at 3 A.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to October 1947 and that I last saw h alive on Oct 26 1947.

Immediate cause of death: Respiratory failure

Due to Arteriosclerotic Cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury I. SGOROFSKY
23. Signature I. Shorofsky M.D.
Address 601 N. Howard St. Date signed 10/27/47 M.D.

VS 150

56393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. C56393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 21-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1155 Sargeant Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph [redacted] P. FLETCHER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah J. Fletcher
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) July 14 - 1884

8. AGE: Years	Months	Days	If less than one day
63	3	12	hr. min.

9. Birthplace Brunswick N. J.
(Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Fidelity Trust Co

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Sarah J. Fletcher
(b) Address 1155 Sargeant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Mrs. John R. Fifer & Son
(b) Address 5311 Edmondson Ave

OCT 28 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1947, at 1.40 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Intracranial Hemorrhage
Due to Contusion of brain.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-26-47 at 9.25 p. M. 21/2
(b) Where did injury occur? outside 1155 Sargeant St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down steps-front house.

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information is required to be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G56394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G56394 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W. University Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. University Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sallie N. Hurst Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Robert White Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1865

8. AGE: Years 82 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name John S. Hurst
13. Birthplace Cambridge, Md.

MOTHER 14. Maiden Name Mary R. Bell
15. Birthplace Newmarket Md.

16 (a) Informant Mrs. Lee W. Boynton
(b) Address Meadow Lane, Hillsdale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Balto #12 (month) (day) (year) Oct 28 1947

(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address McCulloh & Eutaw Sts

19 (a) Oct 28 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1947 8:30: PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18/1934 9, to 10/26/1947, and that I last saw h alive on 10/26/47 19

Immediate cause of death: Carcinoma of the lt. ovary — Duration: About 10 yrs.

Due to —

Due to —

Other Conditions Hypertensive cardio-vascular disease. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin R. Lovell M. D.
Address 11 E. Chase St., City Date signed 10/27/47

G56395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56395

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Broadway
(c) Hospital or institution: Church Home Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 South East Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME MR. Parker Byrd
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 19, 1899
8. AGE: Years 47 | Months 2 | Days 7 | If less than one day ... hr. ... min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Trucking
FATHER 12. Name MR. Parker Byrd
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden Name Miss Lucille Evans
15. Birthplace Virginia
16 (a) Informant Mr. M.C. Rennemore
(b) Address 522 Marion St. NW Washington
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29/47 (month) (day) (year)
(c) Cemetery or crematory Woodland Mem Pk
Location Baltimore
18 (a) Funeral director Philip Henry Lord
(b) Address 2014 Oakland Ave
19 OCT 28 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1947, at 6:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1947 to Oct 26 1947 and that I last saw h.. alive on Oct 26 1947

	Duration
Immediate cause of death pulmonary edema	9 hrs
Due to Cardiovascular efficiency	4 weeks
Due to Chronic myocardial dis	4 years
Other Conditions arteriosclerotic	47 years

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lee M. Howard M. D.
Address Church Home Hosp. Date signed 10/28/47

56396 JL - 50674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C56396

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Thomas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1876

8. AGE: Years	Months	Days	If less than one day
71	1	10	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Boot Black
11. Industry or business

FATHER
12. Name Isaac Thomas
13. Birthplace In South ?

MOTHER
14. Maiden Name Eliza Graham
15. Birthplace ?

16 (a) Informant Ba. Co. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Germany Hill Rd.

18 (a) Funeral director John J. Fahey & Sons
(b) Address 1318 Light St.

19 OCT 28 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1947, at 12N M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1939 to Oct. 22 1947, and that I last saw h. alive on Oct. 22 1947

Immediate cause of death	Duration
Bronchopneumonia	
Due to Arteriosclerotic Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vosburg M. D.
Address Balto City Hosp Date signed 10-28-47

G56397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56397

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wickham Ave
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Magruder Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Harry W Miller

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edna P. Miller
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) May 19, 1875

8. AGE: Years	Months	Days	If less than one day
72	5	7	....hr. ....min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business Insurance

FATHER
12. Name Wickfield Taylor
13. Birthplace Md

MOTHER
14. Maiden Name Rebecca Peterman
15. Birthplace Md

16 (a) Informant Edna P. Miller
(b) Address Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/47 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Howard Co

18 (a) Funeral director Lyon & MacNabb
(b) Address Catonsville Md

19 OCT 28 1947 (Date filed by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1947, at 5:25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1947 to 10/26 1947 and that I last saw h.r alive on 10/26 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchogenic CA, Left Lung	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: CA of Left Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert J. Lurkins M.D.
Address St Agnes Hosp. Date signed 10/29/47

G56398

CWK-113118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. G56398

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 N. Decker Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel C. Gentile

3 (b) If veteran, name war

3 (c) Social Security Account No. 21570-7066

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Separated

6 (b) Name of husband or wife Thelma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9-1896

8. AGE: Years	Months	Days	If less than one day
50	11	18	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Cosmo Gentile
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Palmiano
15. Birthplace Italy

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 31 47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary.
Location Balto Md

18 (a) Funeral director J. A. Bruzzi & Son
(b) Address 1409 Eastern Ave Balto Md

OCT 28 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1947, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18 1947 to Oct. 27 1947, and that I last saw him alive on Oct. 27 1947

Immediate cause of death	Duration
Diabetes Mellitus	
(a) Acidosis	
Due to	
Due to	
Other Conditions Cirrhosis of Liver	
Hypertension and Cardiovascular Disease	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operations:	
of autopsy: Same as above	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Barbaro M.D.
M. D.
Address Balto. City Hosp. Date signed 10-27-47

X

G56399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56399 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 N. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simon Needle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	W.

6 (b) Name of husband or wife Late Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1864

8. AGE: Years	Months	Days	If less than one day
78	5	5	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Yoraecham Tsikel Needle
13. Birthplace Russia

MOTHER
14. Maiden Name Carlyn
15. Birthplace Russia

16 (a) Informant Philip Needle
(b) Address 3206 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28/47 (month) (day) (year)
(c) Cemetery or crematory Ritz Chaim Cemetery
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 424-26 W. North ave

19 Oct 28 1947 (Date received by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1947, at 10:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1937 to October 26 1947 and that I last saw alive on Oct 26 1947.

Immediate cause of death	Duration
Cardiac syncope	
Due to arteriosclerosis	
Due to Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan E. Needle M. D.
Address 2314 West North Ave Date signed Oct 29/47

G56400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

G56400 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) :

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 Belvieu Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Bowley Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Geo. B. Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 29 Nov. 1864

8. AGE: Years	Months	Days	If less than one day
82	10	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business Salesman

FATHER
12. Name George F. Richardson
13. Birthplace ?

MOTHER
14. Maiden Name Mary Bowley
15. Birthplace Baltimore

16 (a) Informant Minnie K. Richardson
(b) Address 4403 Belvieu Ave. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore.
Location Baltimore City, Md.

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 106 West North Ave.

19 (a) OCT 28 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Oct. 1947, at 6:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Oct. 1947 to 27 Oct. 1947 and that I last saw him alive on 26 Oct. 1947

Immediate cause of death	Duration
Hemorrhage, gastric;	3 days.
Due to Carcinoma, pylorus & stomach	weeks
Due to Coronary thrombosis	4 years
Other Conditions Mitral insufficiency, chronic	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Glenn R. Snow
Address Union Memorial Hospital M. D.
Date signed 10/27/47

G56101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 13

Registered No. G56101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 Dundalk Ave
(c) Hospital or institution: Home 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Dundalk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Karolina Michno

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband ~~Wife~~ Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Augustyn
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria ?
15. Birthplace Poland

16 (a) Informant Mr. Peter Michno (Son)
(b) Address 1411 Dundalk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-47 (month) (day) (year)
(c) Cemetery ~~xxxxxxx~~ St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 OCT 28 1947 (Date rec'd by registrar) (Signature of registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27th 1947, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1947, to Oct. 27 1947, and that I last saw h~~e~~r alive on Oct 27 1947.

Immediate cause of death Cancer of mouth/tongue — Duration 1 yr +

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. D. Lipsky M. D.

Address 132 S. Patterson Park Date signed 10/27/47

X

Fill in items with typewriter, pen, or pencil. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56402 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1451 Hull St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jess J Stominski

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-09-6158

4. Sex M | 5. Color or race W | 6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22nd 1903

8. AGE: Years 44 | Months 7 | Days 5. | If less than one day ....hr. ....min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Store Room Keeper.
11. Industry or business Sugar Refinery.

FATHER
12. Name Michael Stominskis
13. Birthplace Poland.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Jessie Stominski
(b) Address 1451 Hull St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Q.A. Co.

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E Fort Ave

19 (a) OCT 28 1947 (Date received by registrar) (b) Registrar Walter Williams M.D.

VS 150^ 1A 1A

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1947, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1947 to 10-27 1947, and that I last saw h. IM alive on 10-26 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Kidney Failure	
Due to Hypertensive Cardio-Vascular Disease	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Harden Mannon Jr. M.D.
Address Md. Gen. Hosp. Date signed 10-27-47

X

G56103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1469

G56103 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Wichita Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Wichita Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie Bernstein

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Michael
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1901
8. AGE: Years 46 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Michael Bernstein
(b) Address 2309 Wichita ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-47 (month) (day) (year)
(c) Cemetery or Crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

OCT 28 1947 (Date rec'd by registrar) (Huntington for Williams) M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27-1947, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/46 19__ to 10/27 1947 and that I last saw h[illegible] alive on 10/27 1947.

Immediate cause of death: Coronary Occlusion — Duration: 1 yr 2 mos
Due to:
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: 8/1947
Major findings of operation: Cor Occlusion
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 23 W Eutaw Pl Date signed 10/28/47 M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 656404

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Arsquith Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Portney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Abrahgun
13. Birthplace Russia

MOTHER
14. Maiden Name Anne
15. Birthplace Russia

16 (a) Informant Anne Portney
(b) Address 205 No Asquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Hovrug Rue

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 Oct 28 1947 Huntington Williams M.D. (Signature of undertaker)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1947, at 8.45 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. (Medical Examiner.)
Date signed 10-27-47

6405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

Registered No. G56105

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3806 Fait Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Fait Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Hugelgans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna A. Duge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1891

8. AGE: Years	Months	Days	If less than one day
55	9	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Sun Papers

FATHER
12. Name J. Peter
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Annie Moll
15. Birthplace Baltimore Md.

16 (a) Informant Anna A. Duge
(b) Address 3806 Fait Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-42 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Coatsville Avenue

18 (a) Funeral director Clayton F. Hoffmann
(b) Address 1639 N. Broadway

19 OCT 28 1941 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1942, at 3:20 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lalumia M.D.
Medical Examiner.
Date signed 10/28/42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

656106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 656106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 3413 Elliott St.
(b) Street address 3413 Elliott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Elliott St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH ELIZABETH PHILLIPS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1865

8. AGE: Years	Months	Days	If less than one day
81	11		hr. min.

9. Birthplace Wales (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John
13. Birthplace Wales

MOTHER
14. Maiden Name Elizabeth Rees
15. Birthplace Wales

16 (a) Informant John P. Phillips
(b) Address 3413 Elliott St.

17 (a) Burial (Burial, cremation, or removal) Date thereof 10 30 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Bonnell Av.

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1689 N. Broadway

10/28 1947 (Date filed by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1947 at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1941 to 27 Oct. 1947, and that I last saw h sc alive on 22 Oct. 1947.

Immediate cause of death — Duration

ARTERIOSCLEROSIS, GENERALIZED — 20 Yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Highstein M. D.
Address 124 S. Highland Ave Date signed 10/27/47

X

6407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. 656407

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Lineclain Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Lineclain Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A Rothamel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife John A Rothamel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17 1862

8. AGE: Years	Months	Days	If less than one day
85	4	9	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Schleucher
13. Birthplace Ger

MOTHER
14. Maiden Name Dont Know
15. Birthplace

16 (a) Informant Mrs Emma Spealman
(b) Address 4215 Erdman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29/47 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2108 Orleans St

19 OCT 28 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26/47 at 9:15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 1947 to Oct 26 1947
and that I last saw h alive on 19

Immediate cause of death: Acute Heart failure — Duration

Due to Arteriosclerotic Cardiovascular Renal Disease

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 3408 Erdman Ave Date signed 10/27/47

56108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G56108 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (5)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 N. Port St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Kordula

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John F. Kordula
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 2, 1875

8. AGE: Years	Months	Days	If less than one day
68	7	6	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Frank Turek
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Struza
15. Birthplace Bohemia

16 (a) Informant John Kordula
(b) Address 903 N. Port St

17 (a) Burial (b) Date thereof Oct 31/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Croggon
(b) Address 900 N Gilmor St

OCT 28 1943 (Date rec'd by registrar) (Huntington Williams M.D.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1943 at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1943 to Oct. 28 1943 and that I last saw h.e.r alive on Oct. 27 1943

Immediate cause of death	Duration
Respiratory Failure.	
Due to Lobar pneumonia, rt. Lower lobe.	7 Days
Due to Post-operative complication.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-30-43
Major findings of operation: Not Known (operation at Mercy 5 wks ago)
of autopsy Not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Herbert S. Kordula M. D.
Address 903 N. Port St Date signed 10-28-43

656109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 656109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. Mercy Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Upperco
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Marguerite Elizabeth Hare

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1918

8. AGE: Years	Months	Days	If less than one day
28	4	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Lee Hare
13. Birthplace — ?

MOTHER
14. Maiden Name Lydia Birdman
15. Birthplace — ?

16 (a) Informant Marcella Hare
(b) Address 818 University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30/47 (month) (day) (year)
(c) Cemetery or crematory Forestone
Location Forest Md

18 (a) Funeral director Edw L Tipton
(b) Address Interred Not Embalmed
(c) Date rec'd by registrar OCT 28 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 - 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1947, to Oct-27-1947, and that I last saw her alive on Oct-27-1947.

Immediate cause of death	Duration
Cerebro-Vascular Hemorrhage	
Due to Thrombosis Toxemic Pregnancy	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebro-Vascular Hemorrhage

PHYSICIAN. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marcella Hare M. D.
Address Kenwood Hosp. Date signed 10/30/47

G56410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1121

G56410 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST JOSEPHS HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County B
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 N. MONTFORD AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MARIE GUNTHER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife CHARLES GUNTHER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/27/91

8. AGE: Years	Months	Days	If less than one day
56	3	0	hr. min.

9. Birthplace BALTO. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name John H. Winter
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Schaefer
15. Birthplace Balto.

16 (a) Informant Chas. M. Gunther
(b) Address 1317 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Langsdale Funeral Home
(b) Address 2401 Belair Rd.

19 (a) 12-29-1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

DC

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1947, at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1947 to 10/27 1947 and that I last saw h[illegible] alive on 10/27 1947

Immediate cause of death INFARCT, LUNG, PNEUMONIA, POST-OP

Duration

Due to PULMONARY EMBOLUS, PERITONITIS,
Due to RUPTURED APPENDIX
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: NOT RECORDED, GANGRENOUS APPENDIX
Autopsy: INFARCT, LUNG, RLL

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry G. Carter M.D.
Address 1400 N. Caroline Date signed 10/27/47

56111
AB-72414

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G56111
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 N. Caroline Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie C. Nichols

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Thomas (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18- 1864

8. AGE: Years 83 | Months 7 | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Old Age Pension

11. Industry or business

FATHER
12. Name Peter Amos (D
13. Birthplace ?

MOTHER
14. Maiden Name Annie Nelson (D
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) 10-28-1947 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150 * ..19

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Oct. 18 19 47, at 5.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10- 19 42, to 10-18 19 47, and that I last saw h. alive on 10-18 19 47.

Immediate cause of death: Bronchopneumonia — Duration: 2 weeks

Due to:

Due to:

Other Conditions: Arteriosclerotic — 7
Cardiac and Diseases of Aorta
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Bal City Hosp. Date signed 11-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

107

G56112 AGNER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Radnor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Radnor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clarence F Agner

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3 1883

8. AGE: Years	Months	Days	If less than one day
64	3	24	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Electrical Mechanic

11. Industry or business

FATHER
12. Name Frank Agner
13. Birthplace Va

MOTHER
14. Maiden Name
15. Birthplace Va

16 (a) Informant Mrs Minnie Walter
(b) Address 507 Radnor Ave

17 (a) Cremation (b) Date thereof Oct 29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 Oct 28 1947 (b) Huntington Williams MD
(Date received by registrar)

VS 150 [redacted]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1947 at 2 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1947 to Oct 1947, and that I last saw him alive on Oct 27 1947

Immediate cause of death	Duration
Myocarditis	
Due to Chronic	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard J. Mullis, M.D.
Address 1 York Court Date signed 10/29/47

Howard J. Mullis, M. D. X

G56113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No. G56113

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3853 Roland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3853 Roland Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bessie Agnes Schneider

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles F. Schneider

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23-1896

8. AGE: Years 51 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state) Maryland

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Samuel A. Sullivan
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella A. Stricklin
15. Birthplace Maryland

16 (a) Informant Charles F. Schneider
(b) Address 3853 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30-1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Quegee Funeral Home
(b) Address 3231 Falls Road

19 (a) 28 1947 (Date rec'd by registrar) (b) Certificate Issued Williamsport Md.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27- 1947, at 10 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1946, to Oct 27 1947 and that I last saw h[illegible] alive on Oct 27 1947

Immediate cause of death	Duration
Cardiac Respiratory failure	
Due to Pulmonary edema	36 hrs.
Due to Retroperitoneal Lymphatic Sarcoma	1 year
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July 9, 1947.

Major findings of operation: Retroperitoneal lymphatic Sarcoma

of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Parker M. D.
Address 1128 Cathedral St Date signed Oct 26 1947

G56114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56114

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Clifton Ave.
(c) Hospital or institution: Clifton Nursing Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2353 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES B. M. PEPPLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
male	white	widower

6 (b) Name of husband or wife Anna E. Peppler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1876

8. AGE: Years	Months	Days	If less than one day
71	6	7	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Tailoring
11. Industry or business

FATHER
12. Name Henry Peppler
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Erma P. O'Donnell
(b) Address Fairfax Apts., 434 Locust Pt. Philadelphia, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

18 OCT 28 1947 (b) Huntington Williams M.D.
(Date Rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1946 to Oct 25 1947 and that I last saw him alive on 10-25 1947.

	Duration
Immediate cause of death Myocardial insufficiency	10 days
Due to Arteriosclerosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J. Daniel M. D.
Address 800 N. Charles St. Date signed 10-28-47

VS 150

656115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 656115

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 Laurens St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Laurens Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY HELEN SHAFER

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	divorced

6 (b) Name of husband or wife: Robert E. Shafer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1874

8. AGE: Years	Months	Days	If less than one day
73	2	10	hr. min.

9. Birthplace: Hagerstown, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Robert E. Orndorff
13. Birthplace: Hagerstown, Md.

MOTHER
14. Maiden Name: Romaine E. Summers
15. Birthplace: Hagerstown, Md.

16 (a) Informant: Mrs. Louise S. Kurtz
(b) Address: 215 Woodlawn Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 OCT 28 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1947, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to October 27, 1947, and that I last saw her alive on 10/27 1947.

Immediate cause of death: Cardio-Renal (Pancreatic Lesion) — Duration: 4 yrs
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Benj. Saylor
Address: 2128 W. North Ave. Date signed: Nov 28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56116 Ful 60 RM

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56116 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 Shields Pl
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Shields Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Fulghum

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	

6 (b) Name of husband or wife Mary E. Fulghum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1873

8. AGE: Years	Months	Days	If less than one day
74	7	26	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address 926 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30, 1937 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Arbutus Md.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St (Assisting for Williams, Mgr.)

19 (a) Oct 28 1937 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1937 at 7 A M

22. I certify that death occurred on the date above stated, that I attended deceased from Oct 13 1937 to Oct 28 1937, and that I last saw h[illegible] alive on Oct 28 1937.

Immediate cause of death: Cerebral Hemorrhage
Contributory
Due to (b) Senility

Duration	
(a)	4 hrs
(b)	1 yrs

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] Cooper
Address [illegible] Date signed 10-30-37

VS 150

G56417 B.C.H.-70581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G56417 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1005 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Larry Coffield ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Infant.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1946.

8. AGE: Years 1 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Coffield.
13. Birthplace Elizabeth City, N.C.

MOTHER
14. Maiden Name Mary Lewis
15. Birthplace Baltimore, Md.

16 (a) Informant Lena Coffield,
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Western Star.
Location Catonsville, Md.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) OCT 28 1947 (b) Huntingdon Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26/47 19 at 10:A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23/47 19 to 10/26/47. and that I last saw h[illegible] alive on 10/25/47.

Immediate Cause of death: Bronchial Pneumonia — Duration: 4 days

Due to EXPOSURE — Duration: 4 days

Due to ACUTE BRONCHITIS — Duration: 4 days

Other Conditions Acute Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. L. Barksdale M. D.
Address 326 N. Carey St. 10/27/47

M.L. BARKSDALE, MD

VS 150

G56418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G56418

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 Pennsylvania Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Penna. Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WARNER

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Widowed

6 (b) Name of husband or wife Mary Warner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25, 1862

8. AGE: Years	Months	Days	If less than one day
85	7	1	hr. min.

9. Birthplace Talbert County, Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William Warner
13. Birthplace Talbert County, Md.

MOTHER
14. Maiden Name Mary Warner
15. Birthplace Talbert County, Md.

16 (a) Informant Rev. Walter M. Warner (Son)
(b) Address 850 Reinhart Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29, '47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Arbutus, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

19 (a) OCT 28 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1947 at 12:15A

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to Oct 26 1947
and that I last saw h[illegible] alive on Oct 26 1947

Immediate cause of death — Duration
Cardiac Hemiplegia — 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature CHARLES T. WOODLAND M. D.
Address [illegible] Date signed Oct 29 47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 656419

656119 / 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 545 W. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 545 W. Lanvale (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY BACON

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/30/1874

8. AGE: Years	Months	Days	If less than one day
73	5	24	hr. min.

9. Birthplace Eastern Shore, Md. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Louis
13. Birthplace Md

MOTHER
14. Maiden Name Julia Gaddis
15. Birthplace Md

16 (a) Informant Rona Waller Brown (Daug)
(b) Address 404 McMechen St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave.

19 (a) OCT 28 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24th 1947, at 7:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1947 to 10/24 1947 and that I last saw h[illegible] alive on 10-23 1947.

Immediate cause of death — Duration

Cardio-Renal

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

6 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. N. Hatcher M. D.
Address 1 W S P. Ave Date signed 10/27/47

B. N. Hatcher

G56420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56420

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2428 E. Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Eaton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Theresa Ward
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: William J. Ward
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 17 - 1873
8. AGE: Years 74 | Months 2 | Days 9 | If less than one day hr. min.
9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Timothy Caffery
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Marguerietta M. Ward
(b) Address 1112 Eaton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 - 30 - 47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director John C. Miller Eye
(b) Address 2405 E. Oliver St

19 OCT 28 1947 (Date rec'd by Registrar) (b) Huntington-Wilkins Funeral Home

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 26 - 1947, at M

21. I certify that death occurred on the date above stated; that attended deceased from 4/1 1947 to 10/26 1947, and that I last saw h[illegible] alive on 10/26 1947

Immediate cause of death: Pulmonary Embolism — Duration 6 days
Due to: Cardiac Failure
Due to: Vascular Disease
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1000 Mt. Vernon Pl. Date signed 10-27-47

G56121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓51B

Registered No. G56121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2863 Chesterfield Ave.
(c) Hospital or institution: Maryland Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2863 Chesterfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Garmatz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ or wife Editta H. Garmatz
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) March 20, 1888

8. AGE: Years	Months	Days	If less than one day
59	7	6	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Conductor
11. Industry or business Penna. R.R.

FATHER
12. Name Herman J. Garmatz
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Woering
15. Birthplace Germany

16 (a) Informant Mrs. Editta Garmatz
(b) Address 2813 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Hayden Ave.

18 (a) Funeral director John C. Melly Sons
(b) Address 2435 E. Oliver St.

19 OCT 28 1947 (Date rec'd by registrar) Washington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Oct 1947, at 6 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 1947 to 10/26 1947 and that I last saw h[illegible] alive on 10/26 1947.

Immediate cause of death	Duration
Uremia	3 days
Due to Carcinoma of Prostate	10 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. A. Corsano M. D.
Address Maryland Gen'l Hosp. Date signed 10/26/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56122 Registered No. G56122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2039 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife Annabel Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/ /1914

8. AGE: Years	Months	Days	If less than one day
33	1		hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Edward Brown
13. Birthplace N. C.

MOTHER
14. Maiden Name Ella Fields
15. Birthplace N. C.

16 (a) Informant Annabell Brown
(b) Address 2039 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Pennsylvania Ave

19 OCT 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1947, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 25 1947 to Oct. 25, 1947 and that I last saw him alive on Oct. 25 1947.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Holly, M.D.
Address 1514 Division St. Date signed 10/28/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G56123 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Ave.
(c) Hospital or institution: St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 das
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Crownsville Md.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Puerto Rico

3 (a) FULL NAME Elisa Cotay

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: Jose Belem Cotay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1898

8. AGE: Years 49 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace Puerto Rico (Town, county and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Antonio Rodriguez.
13. Birthplace Puerto Rico

MOTHER
14. Maiden Name Maria Arroyo.
15. Birthplace

16 (a) Informant Lieut. Robert James Hatton
(b) Address San Rocco Farm, Crownsville, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/29/47 (month) (day) (year)
(c) Cemetery or crematory Central Mercedita Ponce
Location Puerto Rico
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) OCT 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27- 1947, at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1947 to 10/27 1947 and that I last saw her alive on 10/27 1947

Immediate cause of death — Cardiac failure - Atelectasis
Duration
Due to Stomach Duodenum Ulcer - Diabetes
Due to Mellitus
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 10/25/47
Major findings of operation: Chronic Colitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D.W. Hunter M. D.
Address St. Agnes Date signed 10/27/47

056124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (47)

Registered No. 056124

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3410 Devonshire Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-2
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 Devonshire Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: INEZ L. BUHMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: Clifford Buhman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1881

8. AGE: Years	Months	Days	If less than one day
66	9	21	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Lerp
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Katherine Getz
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Clifford Buhman
(b) Address 3410 Devonshire Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.28.47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1947, at 8:10a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to Oct 25 1947 and that I last saw h[illegible] alive on Oct 23 1947

Immediate cause of death: Cancer of Lung — Duration: 1yr?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Milton B Kerr M. D.
Address Med. arts Bldg Date signed 10/27/47

VS 150

C56425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

T 131 B

Registered No. C56425

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 6 days
(e) Length of stay in Baltimore (yrs., mos., or days): 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Talbot
(c) City or town: Saint Michaels
(If outside city or town limits, write RURAL and give town)
(d) Street No.: ---
(If rural give location)
(e) Citizen of foreign country? ---(Yes or No)
If yes, name country:

3 (a) FULL NAME: Ohlendorf Newman

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 218-18-2252

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 3, 1902

8. AGE: Years: 45 | Months: 7 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Neavitt, Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: John O. Newman
13. Birthplace: Neavitt, Md.

MOTHER
14. Maiden Name: Ida May Niblett
15. Birthplace: Neavitt, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 30/47 (month) (day) (year)
(c) Cemetery or crematory: Church Cemy
Location: Neavitt Md

18 (a) Funeral director: John O. Mitchell Home
(b) Address: 19 So Eutaw Place

19 (a) --- (b) Kentington Williams Md
(Date of this certificate) (Signature of registrar)
OCT 28 1947

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28 1947, at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1947, to Oct. 28 1947, and that I last saw h. im alive on Oct. 28 1947

	Duration
Immediate cause of death: Glomerulo-nephritis	5 yrs.
Due to: with uremia) Uremic pericarditis)	3-4days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 10/28/47

X

656126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1246

Registered No. 656126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Broadway
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Eastern Ave. Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME MRS. Anna Mullaney

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John L. Mullaney

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Sept. 7 1875

8. AGE: Years 72 | Months 1 | Days 19 | If less than one day — hr. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Mitchel
13. Birthplace Maryland

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Anna Feehley
(b) Address 3211 Fait ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. - Blvd.

18 (a) Funeral director Jos. L. Connolly
(b) Address 1701 Eastern Ave

19 (a) OCT 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1947 at 7:34 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 1947 to 10/26 1947 and that I last saw h.e.r alive on 10/26 1947.

Immediate cause of death	Duration
Ulceration, Obstruction, Malnutrition.	5 mos
Due to Cirrhosis Liver	10 yrs
Due to Fecal impaction	30 days
Other Conditions Congestive Coll Heart	15 day

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation: —

of autopsy: City Hospitals, Congestive C.H.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Lee Howard M. D.
Address Church Home, Hospital Date signed 10/26

656127 Y

BALTIMORE CITY HEALTH DEPARTMENT

CIOKA CERTIFICATE OF DEATH ✓ 129

Registered No. 656127

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore – Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Poplar & Seven Ave. Chase Park
(If rural give location)
(e) Citizen of foreign country? Roumania (Yes or No)
If yes, name country Bessarabia

3 (a) FULL NAME Theodore Cioka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21 1876

8. AGE: Years 71 | Months 7 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Roumania (Town, county, and state)

10. Usual Occupation Baker (Retired)

11. Industry or business

FATHER
12. Name Theodore Cioka
13. Birthplace Croatia Hungary

MOTHER
14. Maiden Name Zinkovonde ?
15. Birthplace ?

16 (a) Informant Mrs. Helen V. Zybell
(b) Address Poplar & Seven Ave. Chase

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18 (a) Funeral director Thos. F. Connelly
(b) Address 418 Eastern Ave. Essex

19 OCT 28 1947 (Date rec'd by registrar) (b) Transcription from William M.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1947, at 10:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1947 to 10-27 1947, and that I last saw him alive on 10-27 1947

Immediate cause of death	Duration
Gangrene of Perineum, Multiple Arterio sclerosis, Anemia;	
Due to Thrombosis, both Arteries both Lower extremities	
Due to Malnutrition, Heart Failure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-22-47

Major findings of operation: Gangrene, Left Lower Extremity

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carlton Brumfield M. D.
Address Md. Gen. Hosp. Date signed 10-27-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 056128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LINDEN AVE & MADISON ST.
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Fait Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. HELEN R ROUSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Divorced

6 (b) Name of husband or wife ?

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 8-28-1884

8. AGE:	Years	Months	Days	If less than one day
63	62	11	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business State Dept. of Health

FATHER
12. Name Chas. Owens
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Agnes Kiggins
15. Birthplace Balto

16 (a) Informant Virginia Meyers
(b) Address 3108 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Tilley & Zeiler Inc.
(b) Address 403 S. Wolfe St. (Huntington Hotel Annex)

19 (a) [illegible] (Registrar) Registrar

OCT [illegible] 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26- 1947, at 1045 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1947 to 10-26 1947 and that I last saw her alive on 10-26 1947

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to KIDNEY FAILURE

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE

Other Conditions CHRONIC MYELOGENOUS LEUCEMIA

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Harlan Manown Jr. M. D.
Address [illegible] Hosp. Date signed

937

656129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 656129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2738 Edmondson ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2738 Edmondson ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William J. B. Shanks

3 (b) If veteran, name war

3 (c) Social Security Account No. Retired

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Widowed

6 (b) Name of husband or wife Mary Jane Shanks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18 1865

8. AGE: Years	Months	Days	If less than one day
81	11	9	hr. min.

9. Birthplace St. Marys Co. Md. (Town, county, and state)

10. Usual Occupation Retired - Mfg. Carbonated Beverages

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Emma Wheatley
(b) Address 2738 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30 - 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md.
Location Baltimore Md.

18 (a) Funeral director Jeannie Cook Lyford
(b) Address 1600 W. North ave

19 OCT 28 1947 Huntington Williams M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1947 at 2-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1945 to Oct 27 1947, and that I last saw him alive on Oct 27 1947.

Immediate cause of death Myocardial insufficiency. Arteriosclerotic type of heart disease with hypertrophy

Duration: 2 yrs

Disease and Congestive failure

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Michel M. D.
Address 250 Edmondson Ave Date signed Oct 27 1947

V S 150

X

G56430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G56430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5207 Gwynn Oak Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5207 Gwynn Oak Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Fink

3 (b) If veteran, name war

3 (c) Social Security Account No. 152-16-2642

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Fink

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1892

8. AGE: Years: 55 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Phil., Pa.
(Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business

FATHER
12. Name: Joseph Fink
13. Birthplace: Russia

MOTHER
14. Maiden Name: Esther -
15. Birthplace: Russia

16 (a) Informant: Nancy A. Byrum
(b) Address: 2745 - 29th St., N.W., Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-47 (month) (day) (year)
(c) Cemetery or crematory: Woodvert Cemetery
Location: Phil, Penna.

18 (a) Funeral director: Jack Levin, Inc
(b) Address: 2101-02 Eutaw Place

19 (a) Oct 28 1947 (b) Registrar: Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-28, 19 47 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 19 47 to Oct 28 19 47, and that I last saw h— alive on Oct 27 19 47.

Immediate cause of death: Coronary Thrombosis. — Duration

Due to: Diabetes.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Thos. J. Abbott

Address: 4509 Liberty Heights Ave Date signed: 10-29-47

656131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 457

Registered No. 656131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 E.Federal Street
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 E.Federal Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John G.Schneider Sr.

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-16-2842

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Margaret Ann Zang
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 21, 1865

8. AGE: Years	Months	Days	If less than one day
82	7	6	######## hr. ____ min.

9. Birthplace Retired
(Town, county, and state)
10. Usual Occupation Varnisher
11. Industry or business Mantanance Man (Office Building

FATHER
12. Name Sebastian Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Stenger
15. Birthplace Germany

16 (a) Informant Joseph F.Schneider (Son)
(b) Address 2505 E.Federal Street

17 (a) Burial (b) Date thereof 10/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.Balto:Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 28 1947 (b) [signature]
(Date rec'd by registrar)

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1947, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Oct 1947 to 27 Oct 1947, and that I last saw h alive on ____ 19____

Immediate cause of death	Duration
[illegible]	
Due to Fatural burn on out patient	
Fire & Burglars, Hospital, Mass	
Due to hot & gastric phagenitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1513 N. Milton Ave Date signed 10/28/47 M.D.

X

No. 256132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No. 256132

Every item of information should be carefully supplied. Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 27 N. Carey Street
(c) Hospital or institution: Good Samartian Home
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4-9
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: City
(c) City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1119 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mary G. Higgins

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 4/11/1889.

8. AGE: Years: 58 | Months: 6 | Days: 16 | If less than one day: XXXX hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation:
11. Industry or business:

FATHER
12. Name: John T. Higgins
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary Ellen Welsh
15. Birthplace: Baltimore, Md.

16 (a) Informant: John Higgins
(b) Address: 1119 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/30/47. (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Edmondson Avenue, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) Oct 28 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1947 to Oct. 27 1947, and that I last saw h[illegible] alive on Oct 27 1947

Immediate cause of death: Hodgkins Disease — Duration:

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Stelio Impreccia M.D.
M. D.
Address: 1348 Block St. Date signed: 11/3/47

Stelio Impreccia M.D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

G56133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56133

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4417 Glenarm Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4417 Glenarm Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Foreman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
88			hr. min.

9. Birthplace Lith
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Louis Fronesky
13. Birthplace Lith

MOTHER
14. Maiden Name Leah Sachs
15. Birthplace Lith

16 (a) Informant Miss Esther Foreman
(b) Address 4417 Glenarm Ave

17 (a) Burial (b) Date thereof Oct 29, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cemetery
Location Washington Blvd

18 (a) Funeral director Sol Levibson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Oct 28 1947 (b)
(Signature of local registrar) Huntington Mills, Registrar

VS 150

MEDICAL CERTIFICATION 8115

20. DATE OF DEATH October 27 19 47 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1947 to Oct 27 1947, and that I last saw her alive on Oct 27 1947

Immediate cause of death	Duration
Coronary Occlusion	12 Hrs
Due to Hypertension - (Arteriosclerotic Heart Dis.)	Many yrs.
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary K. English M. D.
Address 5713 Belair Rd Date signed 10-28-47

X

G56134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G56134
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-3 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 652- W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SYLVIA BARKSDALE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]1947

8. AGE: Years	Months	Days	If less than one day
	2		hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Locat University Medical School OCT 28 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 28 1947 (b)
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19, 1947, at 8.45 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallis M.D.
Medical Examiner.
Date signed 10-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 656135

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town Bowie
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 28 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 28 1947 (Date rec'd by registrar) Howard Whitehurst M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1947 at 12 10 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Due to Cardiac failure

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-17-47

656136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/13

Registered No. 656136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Johns Hopkins 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) dea.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 E. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Lecha Dyson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 28 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date filed by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19, 1947, at 9 05 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Its death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic bilateral pulmonary tuberculosis with cavity formation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maddocks M.D. Medical Examiner.

Date signed 10-21-47

VS 181

656137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 656137

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert Street
(c) Hospital or institution: Mercy Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 E Lexington St. (If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Brown

3 (b) If veteran, name war
3 (c) Social Security Account No. unknown

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced unknown

6 (b) Name of husband or wife unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace unknown (Town, county, and state)

10. Usual Occupation unknown

11. Industry or business

FATHER 12. Name unknown
13. Birthplace unknown

MOTHER 14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Credentials
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 28 1947

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 28 1947 Baltimore, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1947, at 10:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1947, to Oct 21 1947, and that I last saw him alive on Oct 21 1947.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jane M. J Brugan M.D.
Address Mercy Hospital Date signed Oct 21

656138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91c

656138
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Baren St
(c) Hospital or institution: Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 240 Hanover St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Therone Grant.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 42 Months Days If less than one day hr. min.

9. Birthplace Arkansas (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Information by Records in admission 10/16/47
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 28 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 28 1947 (Date rec'd by registrar) Harry J. Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1947, at 10:45 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 10/6 1947, to 10/16 1947, and that I last saw h[illegible] alive on 10/16 1947

Immediate cause of death	Duration
Acute Cardiac manifestation	
Due to Endocarditis	
Due to Myocarditis	
Other Conditions Chr Bronchitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Mac Murchy M. D.
Address 801 Baren St Date signed 10/16/47

656139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 240

Registered No. 656139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Glencoe
(If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Stanley Bosley Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 4, 1947

8. AGE: Years	Months	Days	If less than one day
	05	24	..... hr. ..... min.

9. Birthplace Balto. Co., Md (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name Stanley Bosley Sr
13. Birthplace Balto. Co. Md

MOTHER
14. Maiden Name Anna Bosley
15. Birthplace Balto. Co. Md

16 (a) Informant Stanley Bosley, Sr.
(b) Address Glencoe Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 1947 (month) (day) (year)
(c) Cemetery or crematory Bosley
Location Sparks, Md

18 (a) Funeral director Samuel M. Brooks
(b) Address Sparks Md

19 (a) Date received OCT 28 1947 Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1947 at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....; and that I last saw h..... alive on ..... 19.....

Immediate cause of death	Duration
Cause Undetermined	
Due to ? Septicemia	
Due to Septicemia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Philip Brucer M.D.
Address Johns Hopkins Hosp Date signed 10-29-47

X

G56140 G56140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 Ridgely
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Ridgely St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma V. Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband Wm A. Hess

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21st 1867

8. AGE: Years 79 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name Joseph Floyd
13. Birthplace Balto Md

MOTHER
14. Maiden Name Hoskinson
15. Birthplace " "

16 (a) Informant Irvin R. Hess
(b) Address 2303 Herkimer St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul Street

19 OCT 29 1947 (Date rec'd by registrar) (b) Huntington Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28th 1947, at 8 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Nov 1942 to 28 Oct 1947 and that I last saw him alive on 27 Oct 1947.

Immediate cause of death: Cyrotic Myocardial Disease — Duration 5 YR
Due to Arteriosclerosis
Due to
Other Conditions Bronchial Asthma — 5 YR
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward J Milan M.D.
Address 68 Wyoming Road Date signed 28 Oct 47
Beltsville-30 Md X

VS 150

G56141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G56141
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 Chapel Gate Lane
(c) Hospital or institution: Pine Crest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 week
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wheeler

3 (b) If veteran, name war

5 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Sylvester A. Wheeler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1883

8. AGE: Years: 64 | Months: 8 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: William Scharon
13. Birthplace: Germany

MOTHER
14. Maiden Name: Sophia Wilden
15. Birthplace: Baltimore Md.

16 (a) Informant: Carrie Scharon
(b) Address: 1826 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-31-47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md.

18 (a) Funeral director: Wm. Cook Jones
(b) Address: 217 N. Paul St.

(Date received by registrar) (By)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1947 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1947 to Oct. 28 1947 and that I last saw her alive on Oct. 28 1947

Immediate cause of death	Duration
Diabetic Coma	
Due to Diabetes Mellitus	
Due to	
Other Conditions Sclerosis of Aorta, Essential Hypertension (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Arthur Rosenberg

Address 2411 West. Blvd. Date signed 10/30/47

G56142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56142 (1551)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Barman Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD S. BARNITZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Martha S. Barnitz

6 (c) If alive, give ~~age~~ 18 ~~years~~

7. Birth date of deceased (mo., day, yr.) June 16 1888

8. AGE: Years 59 | Months 4 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Maillard Inc.

FATHER
12. Name Frank Barnitz
13. Birthplace Md.

MOTHER
14. Maiden Name Rochelle Simmons
15. Birthplace Md.

16 (a) Informant Miss Jane Barnitz
(b) Address 34 Murdock Rd.

17 (a) Burial (b) Date thereof 10/31/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St.

19 OCT 29 1947 (Date rec'd by registrar) Courtesy for Williams M.E. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28/47 19____, at 12:25 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 10/28/47

G56143 61

BALTIMORE CITY HEALTH DEPARTMENT ✓ G56143
CERTIFICATE OF DEATH 94a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5518 Wayne Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5518 Wayne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard G. Warfield

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maude I. Warfield
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) February 20, 1880

8. AGE: Years	Months	Days	If less than one day
67	8	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Asst. Mfgr.
11. Industry or business Graham's Storehouse

FATHER
12. Name Joseph Warfield
13. Birthplace A. A. County, Md.

MOTHER
14. Maiden Name Margaret Garrett
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Maude I. Warfield
(b) Address 5518 Wayne Ave.

17 (a) Burial (b) Date thereof Oct. 29, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Willis Lamotray
(b) Address 4510 Liberty Heights Ave.

OCT 29 1947 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1947 at 2:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1947, to 10/27 1947 and that I last saw him alive on 10/25 1947.

Immediate cause of death	Duration
Coronary occlusion	3½ mo.
Due to Myocardial insufficiency	3 wk.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Reate
Address 3408 Windsor Ave. Date signed 10/27/47

G56144

BALTIMORE CITY HEALTH DEPARTMENT ✓ G56144 Registered No. (Orig)

CERTIFICATE OF DEATH 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3729 Fait Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3729 Fait Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie V. Biscoe

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George Biscoe
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-27-1867

8. AGE: Years 79 | Months 11 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Alex Cunningham
13. Birthplace Balto.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Balto. Welsheck

16 (a) Informant Mrs. Bylchuck
(b) Address 3729 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Ext.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

OCT 29 1947 (Date rec'd by registrar) Huntington Williams, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1947 at 5-40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Oct 26 1947, and that I last saw h.e alive on Oct 26 1947.

Immediate cause of death Cardiovascular renal disease (acute) — Duration 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. A. Lepley M. D.
Address 432 S Patterson Park Ave Date signed 10/28/47

X

G56145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

G56145 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 S. Kenwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore 24
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 S. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Georgianna Smith
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Noah Smith
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/12/62

8. AGE: Years	Months	Days	If less than one day
85	9	16	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business at home

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Smith (son)
(b) Address 1013 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/47 (month) (day) (year)
(c) Cemetery or crematory Cambridge
Location Cambridge

18 (a) Funeral director Lilly & Zeiler, Sts.
(b) Address 407 S. Wolfe Street

OCT 29 1947 (Date rec'd by registrar) (Huntington Williams, M.D.)

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 28th Oct 1947, at 4:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Oct 1947 to 28 Oct 1947, and that I last saw h[er] alive on 28 Oct 1947

Immediate cause of death atypical pneumonia — Duration 1 wk
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address 214 E Fayette St Date signed 10-31-47

G56146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G56146

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3150 Remington Ave
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3150 Remington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen M. Baker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Clarence E. Baker
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1893

8. AGE: Years	Months	Days	If less than one day
54	1	2	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank R. Hodsall.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Rachel H. Wilson
15. Birthplace Maryland.

16 (a) Informant Clarence E. Baker.
(b) Address 3150 Remington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30/47. (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Balto Co, Md.

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) OCT 29 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1947 to Oct 27 1947, and that I last saw h[illegible] alive on Oct 27 19 47

Immediate cause of death	Duration
Cerebral thrombosis	3 days
Due to Arteriosclerosis	
Due to	
Other Conditions Arteriosclerosis Diabetes,	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 4040 N. Charles Date signed 10/29/47

930

G56147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G561477

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 N Durham Sy.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 N Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bruce Powell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Blanche Shinnick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/12/1876

8. AGE: Years 71 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Not known
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Harry McNutt
(b) Address 1803 N.Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 29 47 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 N.Broadway

19 (a) Oct 29 1947 (Filed record by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26. 1947 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1947 to Oct 26 1947, and that I last saw h alive on Oct 26 1947.

Immediate cause of death: Coronary Sclerosis
General Arteriosclerosis — Duration: 5 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Smith M. D.
Address 1223 E. North Date signed 10/28/47

G56148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G56148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3445 Harwell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3445 Harwell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret B. Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles Hopkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25-1869

8. AGE: Years 77 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Winkler
13. Birthplace Balto

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Wm Baldwin
(b) Address 3445 Harwell ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Balto

18 (a) Funeral director Jos J Stanton
(b) Address 3001 Kentucky ave

OCT 29 1947 (Huntington Hill Square Mortuary) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1947, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1947, to 10/27 1947, and that I last saw h.e.r. alive on 10/27 1947.

Immediate cause of death Coronary Occlusion — Duration 27 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen I Hopkins M. D.
Address 3445 N Charles St Date signed 10/28/47

X

G56149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

Registered No. G56149

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 38 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Flagship Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Couper, Jack Edward

3 (b) If veteran, name war: WW II
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife:
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 5-5-23
8. AGE: Years 24 | Months 5 | Days 22 | If less than one day: hr. min.
9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation machinist
11. Industry or business machinist

FATHER
12. Name Samuel Couper
13. Birthplace Phoenixville, Pa.

MOTHER
14. Maiden Name Louise Pettigrew
15. Birthplace Portland, Oregon

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30 1947 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) Oct 30 1947 (b) Washington Williams, M Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1947 at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1947 to Oct. 27 1947, and that I last saw him alive on Oct. 27 1947

	Duration
Immediate cause of death anemia	
Due to Hodgkin's disease	10 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept. 17, 1947
Major findings of operation: Microscopic diagnosis of Hodgkin's Dis.
of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cecil H. Dade M. D.
Address U.S. Marine Hosp. Date signed 10/29/47

G56150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G56450 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2603 Loyola Southway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Loyola Southway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Greenberg

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Lamm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Rose Blum
(b) Address 2603 Loyola Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pikesville Baltimore Co.

18 (a) Funeral director Jewish Funeral Home
(b) Address 2100 Eutaw Pl.

19 (a) 10-29 1947 (Date rec'd by Registrar) (b) Washington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/47 19 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 46 to 10/29 19 47 and that I last saw her alive on 10/29 19 47

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Due to Hypertension	10-15 yrs.
Arteriosclerosis	
Due to Cardiac Hypertrophy	6 mos
Cardiac Insufficiency	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Theodore Cooper M.D.
Address 2201 Eutaw Place Date signed 10/29/47

G56151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G56151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address GREENE AND REDWOOD
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 GREENMOUNT AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAY SHARROW

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife LIBBY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation TAYLOR
11. Industry or business

FATHER
12. Name Joseph Russey
13. Birthplace Russia

MOTHER
14. Maiden Name Susan
15. Birthplace Russia

16 (a) Informant Wife Raised
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-47 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Balto Co.

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Pl.

19 (a) Date of death 1947 (b) Certified by the attending physician Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1947, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1947, to 10-29 1947 and that I last saw h IM alive on 10-29 1947.

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to CARCINOMA OF LUNG (LEFT)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10-28-47
Major findings of operation: INOPERABLE CARCINOMA OF LEFT LUNG
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A R Mansberger Jr. M. D.
Address University Hosp, Balto Date signed 10-29

VS-150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

656452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 656152

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Regal Home
(c) Hospital or institution: Belvedere Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Mary Eichner ALSO KNOWN AS GOSSIE REICHNER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
70	8M		hr. min.

9. Birthplace Russia. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Not Known
13. Birthplace Russia
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Fernwood Rd Balto

18 (a) Funeral director Jos. Sears Inc
(b) Address 2100 Eutaw Place

19 (a) Oct 30 1947 Huntingtor Williams M.D.

VS..150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 (29) 1947 at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1946 to 10-29 1947 and that I last saw her alive on 10-29 1947.

Immediate cause of death Cerebral Thrombosis — Duration

Due to

Due to

Other Conditions Myocard. Infarct.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Nagel M. D.

Address Levindale Home Date signed 10-29-47

HENRY NAGEL X

G56153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-E

Registered No. G56153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1622 E Balto St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 E. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILIP JACOBSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Yetta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Meyer
13. Birthplace Russia

MOTHER
14. Maiden Name Rheny
15. Birthplace Russia

16 (a) Informant Rose Yoppe
(b) Address 1622 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Pk.
Location Woodlawn Mem. Pk.

18 (a) Funeral director Jos. Levin Sons
(b) Address 2100 Eutaw Pl.

(c) 10 29 1947 (Date rec'd by registrar) Huntington Williams

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1947, at 4.1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1935 to Oct 1947, and that I last saw h.. alive on Oct 27 1947

Immediate cause of death	Duration
acute Cardiac Dilatation	
Due to Chronic Myocardial Failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S C Feldman

Address 1449 E Balto St Date signed M. 10 D. 4/47

X

G56154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3647 Cottage Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3647 Cottage Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Leah Greenberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jacob Greenberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — | 1874

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Jacob Greenberg
(b) Address 3647 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Rogers Ave

18 (a) Funeral director Beck Lewis Inc
(b) Address 2420 Eutaw Place

19 OCT 29 1947 (Date rec'd by registrar) (By) Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1947, at 9.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 19 to 1947 1947, and that I last saw h alive on 1947 1947.

Immediate cause of death Asthenia or Broncho heart disease — Duration: years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton B. Kirsch M.D.
Address 2320 Eutaw Pl Date signed 10/30/47

V S 150

C56155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

C56155 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 Pierce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie Mae Holloway.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: C
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Jacob Holloway.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1894

8. AGE: Years 53 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Macon, Georgia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lewis Miller.
13. Birthplace Macon, Georgia

MOTHER
14. Maiden Name Charlotte
15. Birthplace Georgia.

16 (a) Informant Mr. Jacob Holloway.
(b) Address 921 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29 1947 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 29 1947 (b) Signature of registrar Washington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1947, at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 1947 to 10/24 1947, and that I last saw h[illegible] alive on 10/23 1947.

	Duration
Immediate cause of death: Cerebral accident	
Due to: Hypertensive Cardio Renal Vascular Syndrome	1 Mo
Due to:	4 Days
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature B. J. Hatcher M.D.
Address 1705 Pierce Date signed 10-29-47

X

G56456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G56456
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md.
(c) Hospital or institution: 329 N. Schroeder St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 N. Schroeder St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse William Neslitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	married

6 (b) Name of husband or wife Sally Neslitt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8, 1886

8. AGE: Years	Months	Days	If less than one day
61	2	18	hr. min.

9. Birthplace Columbia, S.C. (Town, county, and state)
10. Usual Occupation Gardner
11. Industry or business

FATHER
12. Name John Neslitt.
13. Birthplace S.C.

MOTHER
14. Maiden Name Betty N
15. Birthplace S.C.

16 (a) Informant Sally Neslitt.
(b) Address 329 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date received by local registrar) Washington Williams M.D.

OCT 30

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1947, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1947 to Oct 26 1947.
and that I last saw him alive on Oct 26 1947.

Immediate cause of death	Duration
Pneumonia of Bronchial	4 hours
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Williams M.D.
Address 1134 Washington Date signed Oct 29/47

G56157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G56157 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 Myrtle Ave.
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie or Anna Baker.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Sandy Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1882

8. AGE: Years	Months	Days	If less than one day
65	7	22	hr. min.

9. Birthplace Calvert County, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Joseph Grant
13. Birthplace Calvert County, Md.

MOTHER 14. Maiden Name Maria
15. Birthplace Calvert County, Md.

16 (a) Informant Dorothy Baker
(b) Address 1316 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) Oct 29 1947 (b) Kate Williams Funeral Director

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26-1947, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4-1947 to 10-26-1947, and that I last saw him alive on 9-25-1947.

Immediate cause of death: Carcinoma of uterus — Duration: unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm H. Conguer M. D.
Address 611 N. Caroline Date signed 10-29-47

VS 150

X

G56158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G56158

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Canterbury Road & 39th St.
(If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Anne Patterson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Henry Patterson
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1892

8. AGE: Years	Months	Days	If less than one day
55	0	24	--hr. ---min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name Patrick Kennedy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Flynn
15. Birthplace Philadelphia

16 (a) Informant Mrs. Florence K. Monaghan
(b) Address 5 Upland Road, Roland Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Means and Son
(b) Address 805 N. Calvert Street

19 OCT 29 1947 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1947, at 2:00 A. 2:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1947, to 10/28 1947, and that I last saw h.r. alive on 10/27 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Cirrhosis of liver	
Due to	
Other Conditions Chole-lithiasis	

(Include pregnancy within 3 months of death)
Date of operation 10/15/47
Major findings of operation: Cirrhosis of liver
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Powell Jr. M. D.
Address University Hospital Date signed 10/29/47

G56159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G56159 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 St. John's Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) --y-13
(e) Length of stay in Baltimore (yrs., mos., or days) 86 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 St. John's Road
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country. ---------

3 (a) **FULL NAME** Adelia Clarke Murphy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John T. Murphy
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) 8th Oct. 1861.

8. AGE: Years	Months	Days	If less than one day
86	0	20	--hr. --min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation --------
11. Industry or business --------

FATHER
12. Name Anthony Clarke
13. Birthplace Not obtainable

MOTHER
14. Maiden Name Not obtainable
15. Birthplace Not obtainable

16 (a) Informant James Clarke Murphy
(b) Address 107 St. John

17 (a) Burial (b) Date thereof 10/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 (a) OCT 29 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 28th Oct. 1947, at 8.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to 28 Oct 1947, and that I last saw her alive on 28 Oct 1947.

Immediate cause of death Arteriosclerotic degenerative Cardiovascular disease
Due to Senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph E. Muse Jr. M. D.
Address 3311 St Paul St Date signed 10/28/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56160 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 Richwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Richwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Dorothy) Dorothea Kathleen Hamilton

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eric Hamilton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1903

8. AGE: Years 44 | Months 5 4 | Days 3 | If less than one day hr. min.

9. Birthplace Ind (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James H. Beckwood

13. Birthplace Ind.

MOTHER 14. Maiden Name Violet Claxton

15. Birthplace Ind.

16 (a) Informant Eric Hamilton

(b) Address 504 Richwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31 47 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn Md

18 (a) Funeral director John A. Moran

(b) Address 3700 E. Balt St.

19 (a) OCT 29 1947 (registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1947, at 9 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947, to Oct 1947, and that I last saw HER alive on Oct 28 1947.

	Duration
Immediate cause of death: Hypertensive Cardio Vascular disease	5 mo+
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. V. D. Mack M. D.

Address 513 E. 39th St Date signed Oct 28

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56161 (Registered No.) 957 G56161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Linden Ave
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Shelton Rd #5
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna G. Andrews

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Balto - (Town, county, and state)

10. Usual Occupation Retired Teacher

11. Industry or business

FATHER 12. Name Thos. Henry Andrews
13. Birthplace Md

MOTHER 14. Maiden Name Alice Allen Gott
15. Birthplace Md

16 (a) Informant Stuart Hilcat
(b) Address 521 Old orchard Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Fredericks ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

29 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Oct 1947, at 9:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Oct 1947, to 28 Oct 1947, and that I last saw h[e/er] alive on Oct 28 1947.

Immediate cause of death	Duration
Cerebral vascular accident	3 wks
Due to Hypertensive Cardio vascular disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. Allan Dyer, M.D.
Address Mercy Hosp. Date signed 28 Oct 47

656462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938 650462 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave.
(c) Hospital or institution: St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 150 Overbrook Rd. 28.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mirl Arnold HOOD

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife Thos. J. Hood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name dec'd Henry Arnold.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Alice Haines.
15. Birthplace Md.

16 (a) Informant Mrs. Henry Wallace Kirk.
(b) Address Agnes. Daughter.

17 (a) Burial (b) Date thereof 31 Oct 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick ave

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1901 Eutaw Place

19 (a) (b)
(Date received by registrar) Registrar

OCT 29 1947

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 October 1947, at 2.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Oct 1947 to 28 Oct 1947 and that I last saw h. alive on 27 Oct 1947

Immediate cause of death	Duration
Cerebro-Vascular Hemorrhage	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James C Hamill M.D.
M. D.
Address St Agnes' Hosp. Date signed 29 Oct 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56163 | BALTIMORE CITY HEALTH DEPARTMENT | G56163 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.H.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural - Halethorpe Md (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. 1 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Ray

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1892

8. AGE: Years	Months	Days	If less than one day
55	5	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Washington Navy Yard

FATHER
12. Name Thomas L. Ray
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret E. Bailey
15. Birthplace Maryland

16 (a) Informant Thomas L. Ray
(b) Address 1431 Woodall Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1st (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Loudon Park

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

OCT 29 1947

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1947, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. (Medical Examiner.)
Date signed 10/29/47

VS 151

Dr Thomas B. Aquila
500 E 636164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 656164 Registered No. 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2237 Aisquith Street
(c) Hospital or institution: 91
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2237 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. McCummings

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife James Morris
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1889

8. AGE: Years	Months	Days	If less than one day
58	1	22	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Brennen
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Roche
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. James McCummings
(b) Address 2237 Aisquith Street

17 (a) burial (b) Date thereof 10/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (b) Huntington Williams, M.D.
(Date received by local registrar) Registrar

OCT 29 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1947, at 6:40 A M

21. I certify that death occurred on the date above stated, that I attended deceased from January 1947 to October 28 1947 and that I last saw h Ar alive on OCT 27 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 4 days
Due to Pernicious Cerebral Hemorrhage — Duration 2 yrs
Due to Cerebral Arteriosclerosis — Duration 2 yrs
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas B. Aquila
Address 532 E 22nd St Date signed 10-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 Beechfield Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Beechfield Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Moulton Feast

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William Feast
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1867

8. AGE: Years	Months	Days	If less than one day
80	8	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name James F. Moulton
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Dullamel
15. Birthplace Del.

16 (a) Informant William Feast
(b) Address 305 Beechfield Ave.

17 (a) Burial (b) Date thereof 10/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place.

19 (a) 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1942 to Oct. 27 1947, and that I last saw h-- alive on Oct. 26 1947.

Immediate cause of death	Duration
Coronary Thrombosis	10 m.
Due to Coronary Sclerosis and Rheumatic Arteriosclerosis	5 yr. ?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward F. Gallagher
Address 6209 Frederick Ave. Date signed 10/28/47 M. D.

VS 150

656166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

656166 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Grantley Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Grantley Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET HERR

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: Louis Herr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1874

8. AGE: Years	Months	Days	If less than one day
73	4	5	hr. min.

9. Birthplace Liverpool, England (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER: 12. Name James Ball
13. Birthplace England

MOTHER: 14. Maiden Name Mary Warrick
15. Birthplace England

16 (a) Informant Mrs. Margaret Albert
(b) Address 2914 Grantley Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Signature of registrar) Thomas Williams M.D. Registrar
(Date received by registrar) OCT 29 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14, 1946 to Oct 27, 1947, and that I last saw her alive on Oct 20, 1947.

Immediate cause of death	Duration
Carcinomatosis Abdomen	
Due to	
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 520 Medical Arts Bldg Date signed 10/29/47 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G56167 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fenwick Ave. & Madison St.
(c) Hospital or institution: Maryland Gen'l Hospital 15 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS B. McCORMICK

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	217-22-6566

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Lenetta McCormick (nee Pullen) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1884

8. AGE: Years	Months	Days	If less than one day
63	6	1	hr. min.

9. Birthplace Bellevue, Pa. (Town, county, and state)
10. Usual Occupation Telegrapher
11. Industry or business B. & O. R. R.

FATHER
12. Name James H. McCormick
13. Birthplace Pa.

MOTHER
14. Maiden Name Eliz Kerr
15. Birthplace Pa.

16 (a) Informant Mrs. Lenetta McCormick wife
(b) Address 3000 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address Balto., Md.

19 (a) OCT 29 1947 (Date received by registrar) (b) Registrar No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1947, at 6 55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1947, to 10/29 1947, and that I last saw him alive on 10/29 1947.

Immediate cause of death	Duration
Metastatic Carcinoma ?	2
Due to Recto Sigmoid Junction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/24/47
Major findings of operation: Metastatic Carcinoma Recto Sigmoid Junction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Cerasano M. D.
Address Md. Gen'l Hosp Date signed 10/29

E. A. Cerasano

G56168 BALTIMORE CITY HEALTH DEPARTMENT G56168
Registered No.

CERTIFICATE OF DEATH 171a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 N. Wolfe Street.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harley (HOLLEY) WILSON GAMBLE

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 239-07-1673

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Flora Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/15/1901

8. AGE: Years	Months	Days	If less than one day
46	6 7	10	hr. min.

9. Birthplace: Lake City, S.C. (Town, county, and state)

10. Usual Occupation: Minister

11. Industry or business

FATHER
12. Name: Zackary Gamble
13. Birthplace: S.C.

MOTHER
14. Maiden Name: Mary Wilson
15. Birthplace: S.C.

16 (a) Informant: Harley Gamble (Son)
(b) Address: 528 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/47 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location: Lake City, S.C.

18 (a) Funeral director: Charles G. Cooper
(b) Address: 510-12 N. Carrollton Ave.

19 (a) 11/3/47 (Date rec'd by registrar) (b) Thurston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1947 at 3.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Fracture Cervical Vertebrae

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: N/2

(a) Date of injury 10-25-47 at 12.40 p. M.
(b) Where did injury occur? Ashland & Stirling St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No
(d) Means of injury: Pedestrian struck by st. car

23. Signature Emil L. Rayer M.D.
Medical Examiner.
Date signed 10-27-47

VS 151

656169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 656169

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write th its the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4110 Greenway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County —
(c) City or town Princeton (If outside city or town limits, write RURAL and give town)
(d) Street No. 58 Bayard Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frances Folsom Cleveland Preston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Thomas Jex Preston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21 1864

8. AGE: Years	Months	Days	If less than one day
83	3	8	hr. min.

9. Birthplace Buffalo N.Y. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Oscar Folsom
13. Birthplace Buffalo N.Y.

MOTHER
14. Maiden Name Emmie Harmon
15. Birthplace N.Y.

16 (a) Informant Mr. Richard Cleveland
(b) Address 4110 Greenway

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 31 1942 (month) (day) (year)
(c) Cemetery or crematory
Location Princeton N.J.

18 (a) Funeral director Henry W. Jenkins + Son
(b) Address McCubbin + Orchard Sts.

19 (a) Oct 29 1942 (Date received by registrar) (b) Huntington Williams Md (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1942, at 11:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1942 to Oct 29 1942, and that I last saw h[illegible] alive on [illegible] died on [illegible]

Immediate cause of death Coronary Occlusion — Duration Sudden

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard J. Greeley, M.D.
Address 1403 Parkton Date signed 10/31/42

656470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 50

Registered No. 656470

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County.....
(c) City or town Austin
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 San Gabriel
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Adeline Dalle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ewell

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-26-88

8. AGE: Years 59 | Months 9 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Nigh
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name E. H. Hargrave
13. Birthplace Canada.

MOTHER
14. Maiden Name Victoria Holmes
15. Birthplace Mich.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct 30/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount & Oliver St.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Pl. Lore.

19 (a) OCT 30 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1947 at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1947 to Oct 29 1947 and that I last saw her alive on Oct 29 1947

Immediate cause of death	Duration
Anoxia	15 mins
Due to Respiratory failure	20 mins
Due to Mechanical obstruction to tracheobronchial tree	1 hr?
Other Conditions Carcinoma of breast	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation: Carcinoma of R. breast
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Milton Edgerton
Address Hopkins Hospital Date signed 10/30/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 656471

656471

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 S. East Ave.
(c) Hospital or institution: 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 S. East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM J. THOMPSON

3 (b) If veteran, name war Spanish-American; (c) Social Security No. REBELLION

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna M. Thompson
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) July 3, 1880

8. AGE: Years 67 | Months 3 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Penna. R.R.

FATHER
12. Name James A. Thompson
13. Birthplace Norway

MOTHER
14. Maiden Name Anna McLOUGHLAN
15. Birthplace Ireland

16 (a) Informant Anna M. Thompson (Wife)
(b) Address 705 S. East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4300 Belair Rd.

18 (a) Funeral director Charles L. Zeiler
(b) Address 901 S. Conkling St.

19 (a) OCT 30 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1947 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1947 to Oct 28 1947 and that I last saw h[illegible] alive on Oct 28 1947.

Immediate cause of death	Duration
Cardiac Paralysis	
Right Hemiplegia	
Hypostatic Pneumonia	
Due to Arterio Sclerosis &	5 yrs
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno. Clyde
Address 5010 Drexel Road Date signed M. D. 10-29-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G56172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5520 Sefton Ave.
(c) Hospital or Institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5520 Sefton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie B. Falk

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife John Falk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7th. 1872

8. AGE: Years 75 | Months 2 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James B. Elliott
13. Birthplace Md.

MOTHER
14. Maiden Name --
15. Birthplace Md.

16 (a) Informant Albert Falk
(b) Address 5520 Sefton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto. Co. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 OCT 30 1947 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28/47, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 28 1947, and that I last saw her alive on Oct 28 1947.

Immediate cause of death: Carcinoma Uterus — Duration: 2 years
Due to: —
Due to: —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Strudwick M. D.
Address 3605 Belvin Rd Date signed Oct 29/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G56173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 333 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E. Lunsford
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Charles A. Lunsford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25 1867

8. AGE: Years 79 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Farnham, Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Firrold Douglas
13. Birthplace Farnham, Virginia

MOTHER
14. Maiden Name Anna Elmore
15. Birthplace Farnham Virginia

16 (a) Informant Esther L. McKindless
(b) Address 333 E. North Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-30-47 (month) (day) (year)
(c) Cemetery or crematory Woodland
Location Sampsonia Wharf, Virginia

18 (a) Funeral director Wm. Cook Sons
(b) Address 1217 St. Paul St.

19 (a) OCT 30 1947 (Date rec'd by registrar) Huntington Millington Mgr.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30th. 1947, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29th. 1947 to Oct. 30th. 1947. and that I last saw h- alive on Oct. 29th. 1947.

	Duration
Immediate cause of death: Cerebral Hemmorrhage	1 day
Due to: Arteriosclerosis	unknown
Due to:	
Other Conditions: Hypertension	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lee W. Margaretten M.D.
Address 401 E. 25th. St. Date signed 10/30/47

Howard A. Kelly, M.D.

G56474 BC-4-83960 BALTIMORE CITY HEALTH DEPARTMENT G56474

CERTIFICATE OF DEATH 1104a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 S. Chester Street
(c) Hospital or institution:
- None - - 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 S. Chester Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - -

3 (a) FULL NAME GAIL DOLORES MEADOWS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife - - - -
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) July 18, 1947

8. AGE: Years	Months	Days	If less than one day
	3	11	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business none

FATHER
12. Name David Meadows
13. Birthplace Ohio

MOTHER
14. Maiden Name Evelyn Deloris Gaines
15. Birthplace Ohio

16 (a) Informant David Meadows - Father
(b) Address 533 South Chester Street

17 (a) Burial (b) Date thereof 10-30-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Matthias
Location O'Donnell Street

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S.Wolfe Street

19 (a) OCT 30 1947 (b) Huntington Williams M.D.
(Date filed by Registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH October 29 1947, at 6:50 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Upper Respiratory Infection

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury , at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl S. Royer M.D.
Medical Examiner
Date signed 10-29-47

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56475

A5-7016 22685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G56475 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 E Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Frank Constantine

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-5-47

8. AGE: Years	Months	Days	If less than one day
	5	24	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Emanuel Constantine
13. Birthplace Italy MANNONE

MOTHER
14. Maiden Name Mary Mannone
15. Birthplace Md.

16 (a) Informant records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.
19 (a) (Date received by registrar) (b) Huntington Wills Registrar

OCT 30 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-29- 1947 at 3.5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22- 1947 to 10-29- 1947, and that I last saw him alive on 10-29- 1947

Immediate cause of death: Acute meningococcemia (Fulminating) — Duration 6½ hr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. H. Sparks, M.D.
Address Johns Hopkins Hosp. Date signed 10/29/47 M. D.

Dr. J. W. Mach 656176
6331 Belair Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

656176
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5131 Benton Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5131 Benton Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta M. Kramer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1873

8. AGE: Years	Months	Days	If less than one day
74	8	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Richard Kramer
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Rau
15. Birthplace Germany

16 (a) Informant Mr. George C. Brockmeyer
(b) Address 5131 Benton Heights Avenue

17 (a) Burial (b) Date thereof 10/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) (Date rec'd) (b) Registrar

150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1945 to 10/29 1947, and that I last saw h[illegible] alive on 10/29 1947

Immediate cause of death	Duration
MYOCARDIAL DEGENERATION	2 Yrs.
Due to ARTERIOSCLEROTIC HEART DISEASE	2 Yrs +
Due to	
Other Conditions DIABETES MELLITUS	2 Yrs +

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W Mach M. D.
Address 6331 Belair Rd Date signed 10/29/47

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct data is especially important. Physicians: please write the causes of death clearly and legibly.

~~956177~~ BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1786a

Registered No. [redacted] 956177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonsville Wilkens Ave.
(c) Hospital or institution: Saint Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Gaithersburg Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 Walker Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Myrtle Stone

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Walter (deceased) — 6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 8/5/77

8. AGE: Years 70 | Months 2 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Gaithersburg Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER — 12. Name Edward Gehr
13. Birthplace Hagerstown Md

MOTHER — 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mayberry Howe
(b) Address Gaithersburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/47 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md
(a) Funeral director Dwight L. Chaney
(b) Address Gaithersburg Md

OCT 29 1947 (Date rec'd by registrar) Hermitt F. Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29 1947, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12/1947 to 10/29/1947, and that I last saw her alive on 10/29/1947.

Immediate cause of death Cardiac failure — Duration
Hypertensive C.V.D.
Cerebral hemorrhage accident
Due to Fracture Rt Hip
Due to Hemiplegia - weak
Other Conditions Multiple Contusions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10-5-47 at 8:15 P M
(c) Where did injury occur? Gaithersburg Md (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Fell to floor

23. Signature D.W. Munger M.D.
Address Gaithersburg Md Date signed 10/29/47

VS 150

OCT 30 1947

took received by Medical Examiner Herman J. Mullen M.D.

G56178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56178

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Ba. Co.
(c) City or town Ferndale (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph Hamilton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-31-79

8. AGE: Years	Months	Days	If less than one day
68	1	23	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Abraham Hamilton
13. Birthplace ?

MOTHER
14. Maiden Name ? ?
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30, 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Brooklyn Md.

18 (a) Funeral director Chas. E. Wilson
(b) Address 1010 Bentley Rd

19 (a) Oct 30 1947 (b) Huntington White (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1947 at 10 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1947 to Oct 23 1947 and that I last saw him alive on Oct 23 1947

Immediate cause of death: Miliary Tuberculosis — Duration: unknown

Due to.....

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 25 Oct '47

VS 150

056179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. 056179

Every item of information should be carefully supplied. The MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Ev
correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 W. Franklin Street.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME JOHNNIE ALLEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1908

8. AGE: Years	Months	Days	If less than one day
39	7	7	....hr. ....min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Ben Allen
13. Birthplace Virginia

MOTHER
14. Maiden Name Julia Windley
15. Birthplace Virginia

16 (a) Informant Pearce Allen
(b) Address 1023 Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location.....

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) OCT 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1947, at 11.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Gunshot Wounds of Heart & Brain

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-27-47 at 11.35 P. M.
(b) Where did injury occur? Hoffman & Penna. Ave. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D.
Medical Examiner.

Date signed 10-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 656180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 Rock Glen Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Rock Glen Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Egan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Michael J. Egan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1886.

8. AGE: Years 61 | Months 3 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John W. Garrity
13. Birthplace Unknown

MOTHER
14. Maiden Name Bridget Dulaney
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Falkenwald
(b) Address 408 Rock Glen Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4301 Old Frederick Rd.

18 (a) Funeral director Harry H. Lutzke
(b) Address 4101 Edmondson Ave.

19 (a) Oct 30 1947 (Date filed by Registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1947, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947, to Oct 28 1947, and that I last saw h[illegible] alive on October 29 1947.

Immediate cause of death: Carcinoma of Gall-Bladder — Duration: about 2 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation October 1, 1947

Major findings of operation: Carcinoma of gall-bladder

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo J. Gavan M. D.
Address Canton Hill Ave. Date signed 10/29/47

G56181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 N. Woodington Rd.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 830 N. Woodington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Parturs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife Anita Parturs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1877

8. AGE: Years 70 | Months 4 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Produce Dealer

11. Industry or business

FATHER
12. Name Gatino Parturs
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mrs. John A. Velenovsky
(b) Address 830 N. Woodington Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4500 Old Frederick Rd

18 (a) Funeral director Harry A. Leitzke
(b) Address 4101 Edmondson Ave.

19 (a) Oct 30 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1947; at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from September 1944 to Oct 29 1947 and that I last saw him alive on Oct. 29 1947.

Immediate cause of death	Duration
Acute Gallbladder Attack	1 Day
Due to Coronary Sclerosis	about 3 yrs.
Due to Chronic Myocarditis	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. G. Thomas M. D.
Address 116 Mulberry St. Date signed Oct 30 1947

X

G56182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

Registered No. G56182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2110 N. Fulton Ave.
(c) ~~Hospital~~ or institution:
15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 N Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Mamie Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6, 1897

8. AGE: Years 50 49 | Months 11 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Cambridge Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Berry
13. Birthplace Va.

MOTHER
14. Maiden Name Ella Waters
15. Birthplace Cambridge Md.

16 (a) Informant George Parker
(b) Address 2118 N Fulton Ave

17 (a) Burial (b) Date thereof Nov 1, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. County

18 (a) Funeral director Mrs. Pott. O'Elliott
(b) Address 1129 N Caroline St

19 (a) OCT 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28/47 19 ..., at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25/47 19 ... to 10/28 19 47 and that I last saw he alive on 10/28/47 19 ...

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1129 N Caroline St Date signed 10/28/47

VS 150

G56183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G56183

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2303 SIDNEY AVE
(c) Hospital or institution: 2542

(d) Length of stay in hospital or inst. (yrs., mos., or days) 51-3-15.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 SIDNEY AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMIL C. LEHNERT

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-6096

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife BESSIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 14-1896

8. AGE: Years 51 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace BALTO MD. (Town, county, and state)

10. Usual Occupation FORMAN

11. Industry or business GAS & ELEC CO

FATHER 12. Name H. LEHNERT
13. Birthplace GERMANY

MOTHER 14. Maiden Name M. LINDERMAN
15. Birthplace GERMANY

16 (a) Informant BESSIE E. LEHNERT
(b) Address 2303 SIDNEY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-1-47 (month) (day) (year)
(c) Cemetery or crematory LOUDIN PK
Location FRED Rd

18 (a) Funeral director GEO. H. LEIMBACH
(b) Address 4[illegible] N. LYNDHURST ST

19 OCT 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-47 19 , at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-31 1947, to 10-29-47 19 ; and that I last saw him alive on 10-29-47 19

Immediate cause of death	Duration
Carcinoma, right lung	9 Months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen M. D.

Address 206 S. Gilmor St Date signed 10-29-47

X

G56184

433050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G56184

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 2322 Ruth Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bill Viliski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-5-86

8. AGE: Years	Months	Days	If less than one day
61	6	24	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant ?
(b) Address ?

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Hrt of Mary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave

19 (a) Oct 29 1947 (b) Date Received by Registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-29- 1947 at 3 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20- 1947 to 10-29- 1947, and that I last saw him alive on 10-29- 1947.

Immediate cause of death	Duration
CIRRHOSIS OF LIVER	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ABOR

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Freeman J. Stephens M. D.
Address Johns Hopkins Hosp Date signed 10-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56185

M. 85831 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 Walbrook Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA A. LEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Robert E. Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1867

8. AGE: Years	Months	Days	If less than one day
79	10	16	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: domestic
11. Industry or business

FATHER
12. Name: George R. Kohlenberg
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Georganne Anderson
15. Birthplace: Maryland

16 (a) Informant: Baltimore City Hospitals
(b) Address: 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 30 1947 (Date rec'd by registrar) (b) Interring for Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23rd. 1947 19 , at 7. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6th 1944 to Oct 23 1947 and that I last saw her alive on Oct. 23rd 1947

Immediate cause of death: Broncho - pneumonia — Duration 3 days

Due to

Due to

Other Conditions: Generalized arteriosclerosis — years

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Gordon Craft M. D.

Address: Baltimore City, Md. Date signed 10/30/47

X

G56186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56186

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 N. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Collington Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Kummel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Theresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-22-1870

8. AGE: Years 77 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Clothing cutter

11. Industry or business —

FATHER
12. Name George Kummel
13. Birthplace ?

MOTHER
14. Maiden Name Barbara Forstermann
15. Birthplace ?

16 (a) Informant Theresa M. Kummel
(b) Address 401 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Libby & Zeiler Inc
(b) Address 1903 S. Dukeland St.

19 (a) OCT 30 1947 (Date rec'd by registrar) (b) Huntington White Marsh Md.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1947, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1945 to Oct 27 1947, and that I last saw h alive on Oct 27 1947.

	Duration
Immediate cause of death: Cardiac dilation - C-V. Disease	4 yrs
Chr. Hypertension	
Due to Acute Coronary Occlusion	10-27-47
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ea Johnson M. D.
Address 842 E. 33rd St. Date signed 10-29-47

C56187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C56187

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City or Maryland
(b) Street address 207-S. Loudon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207-S. Loudon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Young.

3 (b) If veteran, name war None

3 (c) Social Security Account No. 219-01-5871

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed or divorced. Widowed.

6 (b) Name of husband or wife Connie Young.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10-1882

8. AGE: Years 65 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county and state)

10. Usual Occupation Machinist.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant Mrs. Blanche Arnold.
(b) Address 207-S. Loudon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31-47. (month) (day) (year)
(c) Cemetery or crematory Mount Carmel Cem.
Location

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

OCT 30 1947
(Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 - 1947, at 5.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 47 to Oct 29 1947, and that I last saw h. alive on Oct 27 1947

	Duration
Immediate cause of death Coronary Thrombosis	Day
Due to Duodenal ulcer	Indefinite
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Palmer J. Gorsuch M. D.
Address 4612 Edmondson Date signed 10/30/47

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

Registered No. G56188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 W. Lexington Street 644 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN RADZEVIC

3 (b) If veteran, name war ✓
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Barbara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant Barbara Radzevic
(b) Address 644 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Joseph Kasinskas
(b) Address 602 Washington Blvd

19 OCT 30 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1947, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Earl L. Royer M.D. Medical Examiner
Date signed 10-28-47

VS 151

G56189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56189

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert Co.
(c) City or town Huntingtown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NOVELL HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/24/42

8. AGE: Years	Months	Days	If less than one day
5	6	5	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Novell Harris
13. Birthplace Md

MOTHER 14. Maiden Name Evelyn Brown
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 1 (day) 47 (year)
(c) Cemetery or crematory St Edmonds
Location Calvert Co

18 (a) Funeral director P L Burrell
(b) Address Owens Frederick Md

19 (a) [redacted] 1947 (b) [illegible] Washington Nat'l Airport, Md
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29 1947 at 6.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24 1947 to 10/29 1947 and that I last saw h[illegible] alive on 10/29 1947

Immediate cause of death	Duration
Increased Intracranial Pressure.	6 mos.
Due to Hydrocephalus	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct 1946
Major findings of operation: Cerebral atrophy
of autopsy: Adhesions Arachnoiditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur M Lang M. D.
Address Johns Hopkins Date signed 10/30/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

656190 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 16 N. Tremont Rd
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Daniel John Weber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Catherine M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-8-1904

8. AGE: Years	Months	Days	If less than one day
43	4	20	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Personnel Supervisor

11. Industry or business Telephone Co.

FATHER
12. Name John Weber
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Norton
15. Birthplace Md.

16 (a) Informant Catherine Weber
(b) Address 16 N. Tremont Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fayette & Fayette St.

19 (a) Oct 30 1947 (b) Received by registrar Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1947, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Sept. 1947 to 28 Oct. 1947 and that I last saw h[illegible] alive on 28 Oct. 1947

Immediate cause of death	Duration
Hypernephroma, Rt. kidney	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 17 March 47

Major findings of operation: Malig. tumor removed - Unable to remove all of autopsy.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. R. Liberto

Address Bon Secours Hosp. Date signed 10/27/47

G56191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. G56191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 Balmore Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Balmore Ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George V. Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
89			hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Randolph R. Tucker

(b) Address 1621 Balmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3-4 (month) (day) (year)

(c) Cemetery or crematory Glassboro

Location Gloucester Co. N.J.

18 (a) Funeral director James A. Stanley

(b) Address 142 N. Stricker St

OCT 31 1947 (Date rec'd by registrar) (b) for Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1947, at 8.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Oct 29 1947 and that I last saw h.. alive on Oct 29 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian L. White M. D.

Address 1802 Penna Ave Date signed 10-30-47

V S 150

G56192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192a

G56192 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 LIGHT ST.
(c) Hospital or institution: SOUTH BALTO. GEN. HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 PATAPSCO ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JOHN WILLIAM GIBSON

3 (b) If veteran, name war: W. W. #1
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Nancy E.
6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1898

8. AGE: Years 49 | Months 3 | Days 22 | If less than one day: hr. min.

9. Birthplace Calvert Co. Md (Town, county, and state)
10. Usual Occupation Pipefitter
11. Industry or business

FATHER: 12. Name John W. Gibson; 13. Birthplace Md
MOTHER: 14. Maiden Name Emma Catterton; 15. Birthplace Md

16 (a) Informant Mrs. Charles Catterton
(b) Address 432 E. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Prince Frederick
Location Calvert Co.

18 (a) Funeral director John F Denny Inc
(b) Address 744 Light St.

19 OCT 31 1947 (Date rec'd by registrar) Arlington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29 1947 at 4:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 1947 to 10/29 1947 and that I last saw HIM alive on 10/29 1947

Immediate cause of death: CARDIO RESPIRATORY FAILURE — Duration:
Due to CARDIAC FAILURE & AURICULAR FIBRILLATION
Due to HYPERTENSIVE VASCULAR DISEASE & AORTIC STENOSIS
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William B. Cooper Jr. M. D.
Address Comm. Bldg. Gen. Hos. Date signed 10/29/47

X

G56193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56193

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5301 Pembroke Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5301 Pembroke Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Kutaner-Kucner-

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Carl Kutaner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7 - 1869

8. AGE: Years 78 | Months 2 | Days 22 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Theodore Smith
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Julia Kutaner
(b) Address 5301 Pembroke Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Philip Herwig Son
(b) Address 2024 Orleans St.

19 Oct 31 1947 Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1947 at 5 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19th to Oct 29 1947, and that I last saw her alive on Oct 29 1947.

Immediate cause of death	Duration
Coronary Thrombosis Oct 29	1947
Due to Myocarditis	1942
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Blechman M.D.
Address 3426 Bank Date signed Oct 30/47

V S 150

A. J. Blechman X

656194 B.C.T. 4. 92560

656194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles St.
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Burchette

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Roy Wendell Burchette
13. Birthplace Elkin, N.C.

MOTHER
14. Maiden Name Cora Cummings
15 Birthplace Lumberton, N.C.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical Schoo OCT 30, 1947

18 (a) Funeral director
(b) Address Commissioner of Hea

19 OCT 31 1947 (Date rec'd by registrar) [illegible] M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1947, at 2:10 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1947 to Oct 28 1947 and that I last saw h im alive on Oct 28 1947.

Immediate cause of death	Duration
Prematurety	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Weisenberger M. D.
Address 912 Brooks Lane Date signed 10/28/47

X

G56495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √137a

Registered No. G56495

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Allendale Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MAX SOLOWAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68	2		hr. min.

9. Birthplace Estonia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant: Dora Soloway
(b) Address 2304 Allendale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-47 (month) (day) (year)
(c) Cemetery or crematory Location: Agudas Achim Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2166 Eutaw Place

19 (a) 11-1-1947 (Date rec'd by registrar) (b) Interred in Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1947, at 3:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1947, to 10-30 1947, and that I last saw h IM alive on 10-30 1947.

Immediate cause of death CARDIAC FAILURE
TOXEMIA — Duration

Due to PERFORATION OF BLADDER

Due to TRANSURETHRAL PROSTATIC RESECTION

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 10-28-47
Major findings of operation: PROSTATIC HYPERTROPHY
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Lerman M. D.
Address Sinai Hospital Date signed 10-30-47

VS 150

G56196 BC#7-7362 BALTIMORE CITY HEALTH DEPARTMENT G56196
CERTIFICATE OF DEATH 159 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2125 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 Maryland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Joseph McCrory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/30/47

8. AGE: Years | Months | Days | If less than one day 1 hr. 15 min.

9. Birthplace Baltimore / Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward McCrory
13. Birthplace Baltimore / Md

MOTHER
14. Maiden Name Catherine Slaughter
15. Birthplace Baltimore / Md.

16 (a) Informant Mrs William McCrory
(b) Address 3797 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Edmund W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) 31 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1947 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1947 to 10-30 1947 and that I last saw him alive on 10-30 1947.

	Duration
Immediate cause of death: Perforated Ulcer	
Due to: Peritonitis 5 hrs	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas Frazier M. D.
Address Bon Secours Hosp Date signed 10-30

VS 150

656197 D.C. # 3-93263

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. 656197

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 E. W. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 Marsh Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Michael McCrory

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/30/47

8. AGE: Years	Months	Days	If less than one day
			1 hr. 35 min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Donald McCrory
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Catherine Sloneker
15. Birthplace Baltimore Md

16 (a) Informant Mrs. William McCrory
(b) Address 3707 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31 1947 (month) (day) (year)
(c) Cemetery or crematory Loudenslager Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Edgar W. Coughlin & Son
(b) Address 924 E. Eager St.

19 OCT 31 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1947, at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1947 to 10-30 1947 and that I last saw h[illegible] alive on 10-30 1947

Immediate cause of death Expiratory Failure — Duration
Due to Premature Labor 5 hrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bert Peters
Address Bon Secours Hosp Date signed 10-30 M. D.

X

G56198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G56198

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. These WILL BE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 W. Fairmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES STANSBURY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Edna D. Stansbury

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1911

8. AGE: Years 36 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Gilbert Stansbury
13. Birthplace Arundal County Md.

MOTHER
14. Maiden Name Agnes Harrison
15. Birthplace Annapolis, Md.

16 (a) Informant Edna D. Stansbury
(b) Address 724 W. Fairmount Av.

17 (a) Burial (b) Date thereof Nov. 1, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Baltimore Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 NOV 31 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1947, at 8:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rogers M.D.
Medical Examiner

Date signed

G56199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56199
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2636 W Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2636 W Franklin St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Nettie E Stonesifer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	215-07-1480

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 - 1885

8. AGE: Years	Months	Days	If less than one day
62	3	1	hr. min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual Occupation Sewing.

11. Industry or business

FATHER
12. Name Joseph Oliver Stonesifer
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Katherine Miller
15. Birthplace Carroll Co Md

16 (a) Informant Mrs Retta Elkins
(b) Address 2636 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31 1947 (month) (day) (year)
(c) Cemetery or crematory Pleasant Valley Cem
Location Carroll Co Md

18 (a) Funeral director Chas J Powell
(b) Address 2427 Edmondson Ave

19 (a) Oct 31 1947 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1947, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1947 to Oct 29 1947 and that I last saw h. alive on Oct 28 1947.

Immediate cause of death	Duration
Hemiplegia - (a)	9 days.
Due to Arteriosclerosis	(b)
Due to Myocardial degeneration	5 days.
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward E. Lippard M.D.
Address 1905 W. Baltimore St Date signed Nov 3 1947

VS 3

X

G56300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56300

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3628 Rexmere Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3628 Rexmere Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN ANGUS BERRYMAN

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Amelia Wood Berryman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1874

8. AGE: Years	Months	Days	If less than one day
72	11	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Stock Salesman
11. Industry or business

FATHER
12. Name John Berryman
13. Birthplace Macon, Ga.

MOTHER
14. Maiden Name Ellen McAlpin
15. Birthplace Macon, Ga.

16 (a) Informant Mrs. Norman Groves
(b) Address 734 Whitmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem. Pikesville, Md.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 31 1947 (Date rec'd by registrar) (b) Interior for Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1947, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17/1947 to 10/29/1947 and that I last saw h[illegible] alive on 10/28/1947

Immediate cause of death	Duration
Myocardial insufficiency	1 day
Due to Chronic myocarditis.	since 4/17/47
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Barnum M. D.
Address 1517 E North Ave. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1164c

Registered No. G56501

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 Walbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Walbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony F. Jenkins

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margaret C. Jenkins nee Crafton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1885

8. AGE: Years	Months	Days	If less than one day
62	5	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER
12. Name Francis X. Jenkins
13. Birthplace Balto. Co

MOTHER
14. Maiden Name Susan H. Bush
15. Birthplace Balto., Md.

16 (a) Informant Mrs. A. F. Jenkins
(b) Address 2102 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/47 (month) (day) (year)
(c) Cemetery or crematory Holy Family Cem.
Location Harrisonville, Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) OCT 31 1947 (Date rec'd by registrar) (b) Tuesday for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-1947, at 9 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/29/47 at M.
(b) Where did injury occur? 2102 Walbrook Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work?
(d) Means of injury Firearm

23. Signature [signature] M.D. Medical Examiner.
Date signed 10-29-47

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 656502

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 Barclay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA E. BURFORD

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Arthur L. Burford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1892

8. AGE: Years	Months	Days	If less than one day
55	8	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard R. Moore
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. Glassmyer
15. Birthplace Baltimore

16 (a) Informant Mrs. Elizabeth M. Vazzana
(b) Address 323 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1947, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-47, to 10-29-47, and that I last saw h[illegible] alive on 10-28-47 19

Immediate cause of death	Duration
Acute Cardiac Failure	1 hr.
Due to Bilateral Bronchopneumonia	7 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Constantine, M.D.
M. D.
Address 234 Conkling St. Date signed 10-31-47

X

G56503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

Registered No. G56503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1926 Brent A
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 53yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Brent A (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed.

6 (b) Name of husband or wife Agnes Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 13, 1894

8. AGE: Years	Months	Days	If less than one day
53	6	14	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Burgess
15. Birthplace Md.

16 (a) Informant Mary Johnson
(b) Address 1926 Brent A

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Mrs. M. Kelson
(b) Address 1303 Pressstman

19 OCT 31 1947 (b) Registrar Huntington Williams M.D.
(Date filed by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1947, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1947 to Oct 27 1947, and that I last saw h alive on Oct 27 1947.

Immediate cause of death Tuberculosis of Lungs — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature Dr William Frey
Address 1938 Penna Ave Date signed 10/30/47

VS 150

G56504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56504 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 616 W Lanvale St
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give location)
(d) Street No. 616 W Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/1896

8. AGE: Years 21 | Months 2 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name James Hawkins
13. Birthplace md

MOTHER 14. Maiden Name Monah Myers
15. Birthplace md

16 (a) Informant Mary Brown
(b) Address 616 W Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo H. Kelson
(b) Address 1303 Presstman St

19 (a) OCT 31 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1947 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ___ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions
(Includes pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed Oct 30, 1947

VS 181

656505 EC 7-3610

BALTIMORE CITY HEALTH DEPARTMENT ✓ 656505
Registered No.

CERTIFICATE OF DEATH 106a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1018 Rutland Ave. (If rural give location)
(d) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Norman DAVIS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8/13/45

8. AGE: Years 2 | Months 2 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Balto City (Town, county and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Jessie Davis
13. Birthplace N.C.

MOTHER
14. Maiden Name Josephine Miller
15. Birthplace Balto City

16 (a) Informant Jessie Davis
(b) Address 1018 Rutland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co Md

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

10/31 1947 Huntington Williams M.D. (Date received by Registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1947 at 6 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute tracheobronchitis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 10/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56506 B.C-2-92479 G56506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Paynor Ave & Dukeland St.
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 59 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4418 Elmwood Ave. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Girl Barnes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-26-47

8. AGE: Years	Months	Days	If less than one day
—	—	—	2 hr. 59 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name Thomas Garrison Barnes
13. Birthplace Balto. md

MOTHER — 14. Maiden Name Jeanne Zepp.
15. Birthplace Martinsburg W. Va.

16 (a) Informant Jeanne Barnes
(b) Address 4418 Renwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-47 (month) (day) (year)
(c) Cemetery or crematory Lawson Park
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Green Mount Ave & 22nd

19 (a) Date filed 11-3 1947 (b) Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/47 19 at 10:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30/47 19 to 10/31/47 19, and that I last saw her alive on 10/30/47 19

Immediate cause of death	Duration
resp failure	
Due to prematurity 2#11	
Due to premature labor	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: prematurity - atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature C. S. Waldrop M. D.
Address MBath Date signed 11/1/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 6565012 ~~6559507~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2134 McCulloh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elijah Adams

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-1140

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months – | Days | If less than one day hr. min.

9. Birthplace Calvert Co Md
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Elijah Adams
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Margaret Thomas
15. Birthplace Calvert Co Md

16 (a) Informant Margaret Curtis (niece)
(b) Address 2134 Mc Culloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2-1947 (month) (day) (year)

(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Wm Brooks.
(b) Address 1463 N. Carey St

19 (a) Nov 2 1947 (Date rec'd by registrar) (b) Huntington Hillman Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1947, at 11 30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Haussin, M.D.
Medical Examiner.
Date signed 10-30-47

G56508 B.C.H. 47-88057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. G56508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2673 Maryland ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 1/2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Edward PHILBRICK

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5 - 1947

8. AGE: Years	Months	Days	If less than one day
	1	26	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Charles A. Philbrick

13. Birthplace Boston, Mass

MOTHER 14. Maiden Name Catherine L. Wentz

15. Birthplace Hartford Co Md

16 (a) Informant Catherine W. Philbrick

(b) Address 1643 Maryland ave

17 (a) Burial (b) Date thereof Nov 1 - 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Edmondson

Location Baltimore Md

18 (a) Funeral director Howard B. Mullins

(b) Address Whole Md

19 (a) Oct 31 1947 (b) Huntington Williams, M.D.
(Local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/1947 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1947 to Oct 31 1947, and that I last saw h[illegible] alive on 10/30 1947

Immediate cause of death	Duration
Hydrocephalus	life
Due to Congenital Malformation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth H. Mortimer M.D.

Address 2706 St Paul St Date signed 10/31/47

VS 150

G56509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56509

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 691 Pierce st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 691 Pierce st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie R. Brice

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Priscilla
15. Birthplace MD.

16 (a) Informant Laura V. Mitchell
(b) Address 419 N. Pine st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1100 Bradley Ave.

19 (a) 11 31 1947 (Date rec'd by registrar) (b) Huntington Hill Cemetery

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/1947, at 8:46 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25/1947 to 10/29/1947, and that I last saw her alive on 10/29/1947.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: Hypertensive Cardio-vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. P. Howell M. D.
Address 601 N. Carrollton Ave. Date signed 10/31/47

VS 150

056510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 056510

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address LINDEN AVE & MADISON ST.

(c) Hospital or institution: MARYLAND GENERAL HOSPITAL

(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3102 N. Hilton Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MRS. DOROTHY PACKHAM MEARS

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.

6 (b) Name of husband or wife C. Emmerich Mears

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1895

8. AGE: Years 52 | Months 9 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER

12. Name Harry Packham

13. Birthplace Baltimore

MOTHER

14. Maiden Name Clara E. Stamp

15. Birthplace Nottingham, Md.

16 (a) Informant Mr. C. E. Mears

(b) Address 3102 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 31 1947 (Date rec'd by registrar) (b) Evelyn [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 October 1947, at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1947, to 10-31 1947, and that I last saw her alive on 10-30 1947.

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to MULTIPLE METASTATIC MALIGNANCY

Due to CARCINOMA OF LEFT BREAST.

Other Conditions CHRONIC LYMPHOCYTIC LEUKEMIA

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John Gordon Monmouth, M.D.

Address Md. Gen. Hosp. Date signed 10-31-47

X

G56511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G56511

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 Dobler Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE GRIFFITHS

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harry P. Griffiths
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Dec. 18, 1892
8. AGE: Years 54 | Months 10 | Days 13 | If less than one day hr. min.
9. Birthplace: Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Patrick Flynn
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Maria Corcoran
15. Birthplace: Ireland

16 (a) Informant: Mr. Harry P. Griffiths
(b) Address: 2113 Dobler Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/47 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem. Pk.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) OCT 31 1947 (Date rec'd by registrar) (b) Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1947, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1947 to Oct 31, 1947, and that I last saw her alive on Oct 31, 1947.

Immediate cause of death: CEREBRAL HEMORRHAGE — Duration:
Due to: HYPERTENSION
Due to: ARTERIOSCLEROSIS
Other Conditions
(Include pregnancy within 3 months of death.)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harold Sussman M. D.
Address: Sinai Hospital Date signed Oct 31/1947

McKeever

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

G56512 — Registered No. G56512

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 00
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2137 East Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna A McKeever

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: George A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace: not known
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: not known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant " "
(b) Address " "

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/47 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem.
Location: Taylor Ave.

18 (a) Funeral director: Clarence F. Hoffmann
(b) Address: 1639 Broadway.

19 (a) OCT 31 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1947, at 8 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/30/47 M.
(b) Where did injury occur? 2137 East Chase St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Asphyxiation of illuminating gas

23. Signature [signature] Medical Examiner M.D.

Date signed 10/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 45F

Registered No. 056513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 E.Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 E.Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter L.Auld

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mildred (Mary) Roche
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan.5,1906
8. AGE: Years 41 | Months 9 | Days 26 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Book Binder
11. Industry or business U.S. Printing office

FATHER
12. Name Walter J.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lula Bradyhouse
15. Birthplace Baltimore

16 (a) Informant Mrs. Mildred (Mary) Auld
(b) Address 1618 E.Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Clarence E.Hoffmann
(b) Address 1639 Broadway.

19 (a) Oct 31 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1947, at 3 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1945 to Oct 31 1947. and that I last saw h alive on Oct 30 1947.

	Duration
Immediate cause of death: Carcinoma of Pharynx with Metastasis	2 years
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sol Smith Jr. M. D.
Address 1223 E. North Date signed 10-31-47

VS 150

X

656511 B.C. A-16925 BALTIMORE CITY HEALTH DEPARTMENT 6 656514

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Down. Edwood St.
(c) Hospital or institution:
University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 679 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L. Flynn Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 19th 1947
8. AGE: Years — Months 6 months — Days 12 — If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name James L. Flynn Sr.
13. Birthplace Philadelphia

MOTHER
14. Maiden Name Veronica M. Baker
15. Birthplace Baltimore, Md.

16 (a) Informant Mr James L. Flynn Jr
(b) Address 679 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/47 (month) (day) (year)
(c) Cemetery or crematory St. Joseph Cem
Location Irvington Md.

18 (a) Funeral director John J. Gannon & Sons
(b) Address 907-63 Hollins St.

19 (a) OCT 31 1947 (Date rec'd by registrar) (b) Waiting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1947, at 5:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1947, to Oct. 31 1947, and that I last saw him alive on Oct. 31 1947.

	Duration
Immediate cause of death: Vascular Collapse (shock)	
Due to: Bacteremia	
Due to: Meningococci	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Post. Morton changes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. Brennan M.D. M. D.
Address Un. Hospital Date signed 10/31/47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

356515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 300

Registered No. 356515

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2217 Aiken St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Aiken St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOMENICO GATTO

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Martha S. Gatto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1863

8. AGE: Years	Months	Days	If less than one day
84	6	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Domenico Gatto
13. Birthplace Italy

MOTHER
14. Maiden Name Rachel -
15. Birthplace Italy

16 (a) Informant Mr. Leo Kayer
(b) Address 2802 E. Jefferson St.

17 (a) Burial (b) Date thereof 11/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 31 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1947, at 12:45M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1923, to Oct 30 1947, and that I last saw h alive on 19

Immediate cause of death	Duration
MYOCARDIAL DEGENERATION	2 WEEKS
Due to TABES DORSALIS	25 YEARS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Otto Hoffmann M D
M. D.
Address 8 E. Read St Date signed 10/31/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56516 cc 4 90257 BALTIMORE CITY HEALTH DEPARTMENT Registered No. C56516

CERTIFICATE OF DEATH 1947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 4
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 N. Pine Street.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME THEODORE SHIPLEY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/2/47

8. AGE: Years	Months	Days	If less than one day
	3	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Samuel Shipley
13. Birthplace Maryland

MOTHER
14. Maiden Name Robenette Butler
15. Birthplace Maryland

16 (a) Informant Robenette Shipley
(b) Address 307 N. Pine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director Wilbain A. Jackson
(b) Address 916 Penna, Ave

19 (a) OCT 31 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1947, at 1.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxia due to aspiration of vomitus.

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.....

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 10-30-47

4/2

X

G56517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1362

G56517

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Myrtle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eddie Fields

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-06

8. AGE: Years: 41 | Months: 1 | Days: 21 | If less than one day: hr. min.

9. Birthplace Le Mass, S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Bonnie Fields
13. Birthplace S.C.

MOTHER
14. Maiden Name Ida Deaken
15. Birthplace S.C.

16 (a) Informant Curtis Fields
(b) Address 1292 Short Ct. Apt. B.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Balto. Maryland

18 (a) Funeral director William A Jackson
(b) Address 916 Penna. Ave

19 (a) OCT 31 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1947, at 9:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Kruger, M.D.
Medical Examiner
Date signed 10/31/47

VS 181

G56518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G56518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 S. Clinton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HERBERT NIBLETT

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1915

8. AGE: Years	Months	Days	If less than one day
31	10	14	hr. min.

9. Birthplace Newton County Ga.
(Town, county, and state)

10. Usual Occupation

11. Industry or business American Can Co

FATHER
12. Name J. B. Niblett
13. Birthplace Jasper Co Ga.

MOTHER
14. Maiden Name Etta Sammons
15. Birthplace Bade Co Ga.

16 (a) Informant The E. H. Almand Co Inc
(b) Address Monroe Ga (Funeral Director)

17 (a) Burial (b) Date thereof Nov 3-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Monroe
Location Georgia

18 (a) Funeral director Ellsworth Almand
(b) Address 3911 Liberty Heights Ave.

19 (a) OCT 31 1947 (b) Huntington Williams
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1947, at 9:20PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema.
Edema of brain.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 10-28-47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 56519

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Linden ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.....

3 (a) FULL NAME Mrs Cathryn Ziegler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: femal | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Harold B. Ziegler

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1899.

8. AGE: Years	Months	Days	If less than one day
48.	1.	9	..... hr. ..... min.

9. Birthplace Charlestown W. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles F. Vinds.
13. Birthplace Charles Town W. Va.

MOTHER
14. Maiden Name Ella Schultz.
15. Birthplace Charles Town W. Va.

16 (a) Informant Mrs. H. B. Ziegler.
(b) Address 1713 Linden ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/47 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 S. Paul St

19 (a) Nov 1 1947 (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30-47 19..., at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26-47 19..., to 10-30 1947, and that I last saw her alive on 10-30 19 47.

Immediate cause of death Renal failure	Duration
Due to Cancer of cervix.	
Due to.....	
Other Conditions.....	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.....

23. Signature Robert R. Hahn M. D.
Address University Hosp. Date signed 10-30-47

X

G56520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G56520 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 McHechen Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. HECK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) May 3rd 1883

8. AGE: Years	Months	Days	If less than one day
64	5	27	hr. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business John T. Carter

FATHER
12. Name John P. Heck
13. Birthplace Cumberland Md.

MOTHER
14. Maiden Name Mary C. Newmeyer
15. Birthplace Cumberland Md.

16 (a) Informant Mrs. E. C. Preston
(b) Address Cumberland Md.

17 (a) Burial (b) Date thereof Nov. 1st 1947
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1947, at 3.15 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Edema
Arteriosclerotic C.V.
Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed 10-30-47

VS 191

656521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 656521

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 Madison Av
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Madison Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Winifred Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-1877

8. AGE: Years	Months	Days	If less than one day
70	-	18	hr. min.

9. Birthplace Middlesex Va
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name George Thurston
13. Birthplace Middlesex Co Va

MOTHER
14. Maiden Name Frances Lockley
15. Birthplace Middlesex Co Va

16 (a) Informant Mrs. Fannie Hellmann
(b) Address 1301 Madison Ave.

17 (a) C (Burial, cremation, or removal) (b) Date thereof Nov. 2, 1947 (month) (day) (year)

(c) Cemetery or crematory Amberg Va.
Location Middlesex Co. Va.

18 (a) Funeral director J Preston Amberg
Address 514 N Mosher St.

19 (a) NOV 1- 1947 (Date rec'd by registrar) (b) Lexington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1947, at 11 PM. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to 10-28 1947 and that I last saw h[illegible] alive on 10-28 1947

Immediate cause of death	Duration
hypertensive cardio-renal disease	Several yrs
Due to	
Due to	
Other Conditions osteo-arthritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M.D.

Address 1500 E. Madison St Date signed 11/1/47

VS 130

Rayner Browne X

G566522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 937

Registered No. G566522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3607 Kimbel Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Phila (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Dyre Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella V Tippett

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Claude Tippett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1877

8. AGE: Years	Months	Days	If less than one day
70	1	12	hr. min.

9. Birthplace Danville Pa (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Jacob Mayer
13. Birthplace Pa

MOTHER
14. Maiden Name Don't Know
15. Birthplace Pa

16 (a) Informant Mrs Ray Kramer
(b) Address 1713 Dyre Ave Phila 24 Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) NOV 1 - 1947 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1947 to 10-30 1947 and that I last saw h alive on 10-30 1947

Immediate cause of death Cerebral Thrombosis — Duration 3 days
Due to Hypertension
Due to Uremia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred Ullrich
Address 2008 N Orleans St Date Nov 1 1947

656523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 656523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N. Washington St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD HURT

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/19/74

8. AGE: Years	Months	Days	If less than one day
72	11	11	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Pensioned Balt Trust Co.
11. Industry or business

FATHER
12. Name Charles Hurt
13. Birthplace Czech

MOTHER
14. Maiden Name ? Kessler
15. Birthplace Czech

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof Nov 3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loraine Cem
Location Balto Md

18 (a) Funeral director Lloyd Funeral Home
(b) Address 2008 Orleans St

19 (a) NOV 1 1947 (b) Huntington Wills
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1947, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28/47 19 to 10/30 1947 and that I last saw him alive on 10/30 19 47

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Sclerotic Heart Disease	
Due to	
Other Conditions Terminal Bronchopneumonia R.U. L.L., due to pneumococci (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: about

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas D Hopkins M. D.
Address Johns Hopkins Hosp. Date signed 10-31-47

VS 150

656524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. 656524

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1115 N Fremont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 N Fremont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary Fields
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 4, 1899

8. AGE: Years	Months	Days	If less than one day
48	3	25	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Fields
(b) Address 1115 N Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/47 (month) (day) (year)
(c) Cemetery or crematory Lee Hall
Location Lee Hall, Va.

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) NOV 1 - 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 19 47, at 3 30 P.M.

21. I certify that death occurred on the date above-stated; that I attended deceased from Oct 13 19 47 to Oct 29 19 47 and that I last saw h[illegible] alive on Oct 27 19 47

Immediate cause of death Chronic Arthritis — Duration 1 yr.

Due to 2nd degree burn of right leg and foot — Duration 5 days

Due to Chronic Vascular Disease — Duration 1 yr.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide~~, or ~~homicide~~ Oct 25 / 47
(b) Date of occurrence Oct 25 47 at 7 P.M.
(c) Where did injury occur? Balto (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Scalded with hot water
23. Signature William Frey
Address 1928 Penna Ave Date signed Nov 30 / 47

VS 150

Howard J. Mencken M.D.

656525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 656525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3122 Grindon Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3122 Grindon, Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN L. HENNEBERGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	214-01-6969

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Amy R. Henneberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1884

8. AGE: Years	Months	Days	If less than one day
63	4	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Secretary Treasurer
11. Industry or business English & American Tailoring

FATHER
12. Name Geo. L. Henneberger
13. Birthplace Michigan

MOTHER
14. Maiden Name Annie C. Schneider
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Amy R. Henneberger
(b) Address 3122 Grindon Ave.

17 (a) Burial (b) Date thereof 11/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) NOV 1 - 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/47 19, at 1:00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Ware M.D.
Medical Examiner.
Date signed 10/31/47

VS 151

056526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 056526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3242 Stafford St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3242 Stafford St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence V. Slunt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John J Slunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 4 1892

8. AGE: Years: 55 | Months: 5 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: At home

11. Industry or business

FATHER
12. Name: J. Harry Kirchhoff
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Emma Shriver
15. Birthplace: Baltimore Md

16 (a) Informant: John J. Slunt
(b) Address: 3242 Stafford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3 1947 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore Md

18 (a) Funeral director: Harry Hunnicutt
(b) Address: 4204 Ridgewood Ave

NOV 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1947, at 11:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1947 to 10/31 1947, and that I last saw h[illegible] alive on 10/30 1947

	Duration
Immediate cause of death: Cardiac failure	1 day
Due to: Heart Block	2 days
Due to: Arteriosclerosis	?
Other Conditions: Hypocardia Insufficiency	?

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H. H. Clemens M.D.
Address 3325 Med-Dent Date signed 11/1/47

Dr. Schmitz
701 N. Kenwood Avenue

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 656527

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4314 Biddison Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4314 Biddison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Wilhelmina (Minnie) Etzel
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John L. Etzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1868

8. AGE: Years	Months	Days	If less than one day
78	10	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Christian Gunther
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina
15. Birthplace Germany

16 (a) Informant Mr. Simon Etzel
(b) Address 4314 Biddison Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 NOV 1 - 1947 (Date rec'd by registrar) (b) Certificate for Williamina [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31st, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1947 to Oct. 31 1947, and that I last saw h[illegible] alive on Oct 31 1947

Immediate cause of death Hypertension Cardio-vascular disease — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. J. Schmitz
Address 701 N. Kenwood Ave. Date signed 11/1/47 M.D.

V S 150

Wm. J. Schmitz

656528 B.C.
4-87823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. 656528

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1846 N. Mary St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD A. KIRBY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27 1947

8. AGE: Years | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Thomas Kirby
13. Birthplace Mc Kees Rocks - Pa

MOTHER 14. Maiden Name Dorothy Stuart
15. Birthplace Washington Pa

16 (a) Informant Edward Thomas Kirby
(b) Address 1846 N. Mary St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-47 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Mc Kees Rocks Pa.

18 (a) Funeral director John C Wiley Sons
(b) Address 2435 E Oliver St

NOV 1 1947 (Date Rec'd by Registrar) (Huntingtown Maryland) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1947 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1947, to 10 31 1947, and that I last saw h[illegible] alive on 10-31 1947.

Immediate cause of death	Duration
Circulatory collapse	
ASTATIC	
Due to Hypertrophic pyloric stenosis - postoperative	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-29-47

Major findings of operation: Hypertrophic pyloric stenosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Gabrielsen M. D.
Address University Hosp Date signed 11-2-47

X

056529 FL - 114721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 056529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 536 Orchard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Bullock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Grant
6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) May 4, (1858)?

8. AGE: Years	Months	Days	If less than one day
62 (89)?	5	24	hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Mingo Ellis
13. Birthplace S. C.

MOTHER
14. Maiden Name Milinda Ellis
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-47 (month) (day), (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) NOV 1 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1947, at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1947 to Oct. 28 1947 and that I last saw her alive on Oct. 28 1947

	Duration
Immediate cause of death Congestive Heart Failure.	2 wks.
Due to Hypertensive C.V.D.	yrs.
Due to	
Other Conditions S T S +	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Arabone + Nephrosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Emmett Beaslan M.D.
Address Balto (illegible) Date signed 29 Oct 47

VS 150

93

656530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

656530 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 West Rogers Ave.
(c) Hospital or institution:
Home for the Aged of the Methodist Church of Baltimore City
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1939
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 West Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUNICE MAY O'NEILL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 9, 1869

8. AGE: Years	Months	Days	If less than one day
78	9	22	hr. min.

9. Birthplace Greensboro, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Rev. William J. O'Neill
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary A. Chickering
15. Birthplace Walpole, New Hampshire

16 (a) Informant Miss W. Adele O'Neill sister
(b) Address 2210 Roslyn Ave.

17 (a) Removal (b) Date thereof 11/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Hill Cem.
Location Philadelphia, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1947, at 12:25 pm

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1947 to 10-31- 1947 and that I last saw her alive on Oct-31 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davis M. D.
Address 800 W 38th St Date signed 11-1-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56531 (Registered No.) G56531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2859 Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2859 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL BLITZ

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife LENA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation BAKER
11. Industry or business

FATHER
12. Name NOAH BLITZ
13. Birthplace POLAND

MOTHER
14. Maiden Name RACHAEL
15. Birthplace POLAND

16 (a) Informant LENA BLITZ - WIFE
(b) Address 2859 COLD SPRING LANE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-2-47 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL RD + HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PL

19 (a) 1947 (Date) (b) [illegible] (By registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31-47 19 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 to 10/31 1947, and that I last saw h. alive on 10/31/47 19

Immediate cause of death	Duration
(a) Myocardiac Heart disease	years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 7320 Eutaw Pl Date signed 11/31/47 M. D.

656532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

656532 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 E. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael D. Jacobson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mrs Lillian Douglas
(b) Address 2002 E Pratt St

17 (a) Burial (b) Date thereof 11-2-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Lewin Inc
(b) Address 200 Eutaw Place

NOV 2 1947 (Date rec'd by registrar) (b) Arthur Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1947 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1947 to Nov. 1 1947 and that I last saw him alive on Nov. 1 1947

Immediate cause of death: Acute Cardiac-Vascular Decompensation — Duration 1 hr.

Due to: Chr. Myocarditis — 2 yrs.

Due to: Senile Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mrs. Douglas
Address 2002 E Pratt St Date signed 11/4/47 M.D.

V S 150

656533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 656533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20da
(e) Length of stay in Baltimore (yrs., mos., or days) 38yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Cole St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Fannie Kallenstein or Kallechstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Married.

6 (b) Name of husband or wife Israel.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Bogel Moore
13. Birthplace Poland.

MOTHER
14. Maiden Name Hinda
15. Birthplace Poland.

16 (a) Informant Mrs. Pearl Kessler
(b) Address 1715 Cole St.

17 (a) Burial (b) Date thereof Nov 2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holur Westleyfer Rd
Location Westleyfer Beltd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) [illegible] (b)
(Delivered by registrar) Registrar
NOV 2 1947
Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1947, at 9:55 M a

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1947 to 10-31 1947 and that I last saw her alive on 10-31 1947

Immediate cause of death	Duration
Cardiac failure	
Due to myocardial degen	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C B Mearns M. D.
Address Univ. Hosp. Date signed 10-31-47

X

G56534 G56534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 Pontiac Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 Pontiac Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Wm Turner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Beulah B Turner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14 1869

8. AGE: Years 78 | Months 1 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Phila Pa
(Town, county, and state)

10. Usual Occupation Bank Clerk

11. Industry or business Annapolis Banking Co

FATHER
12. Name Frank Turner
13. Birthplace Ireland

MOTHER
14. Maiden Name Mulvanna
15. Birthplace Unknown

16 (a) Informant Mrs Beulah Turner
(b) Address 221 Pontiac Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4-47 (month) (day) (year)
(c) Cemetery or crematory Hurst Cem
Location Pulaski Va.

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1947; at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to Nov 1 1947 and that I last saw him alive on 11/1 1947.

Immediate cause of death	Duration
Heart failure due to Hypertension	
Due to Cerebral vascular disease.	
Due to	
Other Conditions Chronic nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Eutaw Pl Date signed 11/1/47

V8 180

937

G56535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G56535
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 E. Randall
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 E Randall St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie V. Fritz

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: William H. Fritz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July [illegible] 1881

8. AGE: Years 66 | Months 3 | Days 11 | If less than one day: hr. min.

9. Birthplace Balto (town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Samuel Hyde
13. Birthplace Balto Co. Md.

MOTHER
14. Maiden Name Caroline Diehlman
15. Birthplace Md.

16 (a) Informant William H. Fritz
(b) Address 900 E Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore

18 (a) Funeral director A. Howard Evans
(b) Address 1410 N. Charles St.

19 (a) 1947 (Date rec'd by registrar) Huntington Hills (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1947 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944 to Oct. 30 1947, and that I last saw her alive on Oct. 29, 1947.

	Duration
Immediate cause of death: Cerebral hemorrhage	
Due to: Cerebral and general arteric sclerosis	3 years. 3 mos. 10 days
Due to:	
Other Conditions: Hypostatic pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Perry Dodell M. D.
Address 1026 Hanover St. Date signed 11/1/47

V S 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656536 BALTIMORE CITY HEALTH DEPARTMENT 656536
CERTIFICATE OF DEATH 93E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 292 Dallas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLIFFORD WILLIAMS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife. Fay Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1902

8. AGE: Years 45 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Middletown O.
(Town, county, and state)

10. Usual Occupation Welder

11. Industry or business Md. Drydock

FATHER
12. Name John
13. Birthplace

MOTHER
14. Maiden Name Lillie Clemons
15. Birthplace

16 (a) Informant Anne Menkay (Sister)
(b) Address R. F.D. 1 Stat Mo.

17 (a) Removal (b) Date thereof 11/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hamilton O.
Location

18 (a) Funeral director Tilman Cook Inc
(b) Address 1217 St Paul St.

19 (a) (Date rec'd by registrar) Wilmington Williams M.D. Registrar

NOV 2 1947

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1947, at 1.30 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema

Due to acute congestive heart failure

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Ryan M.D.
Medical Examiner

Date signed 10-30-47

G56537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G56537

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 Venable Avenue
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Venable Avenue
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Michael J. Cahill

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widowed

6 (b) Name of husband or wife Mary Cahill
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1858

8. AGE: Years	Months	Days	If less than one day
89	1	1	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Packer
11. Industry or business

FATHER
12. Name Michael J. Cahill
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Benjamin F. Westerfield
(b) Address 618 Venable Avenue

17 (a) burial (b) Date thereof 11/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) ..... (b) for Williams, Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1947, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 1947 to Oct 30 1947 and that I last saw h.IM alive on OCT 30 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to auricular fibrillation	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
.....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Russell K. Lambert M. D.
Address 2116 W. Pratt ST. Date signed 10/31/47

VS 150

G56538

438070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

G56538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Delaware (b) County
(c) City or town Wilmington (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Shipside (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS BOURDON

3 (b) If veteran, name war	3. (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/xx/47

8. AGE: Years	Months	Days	If less than one day
	3	9	hr. min.

9. Birthplace Del (Town, county, and state)
10. Usual Occupation ✓
11. Industry or business ✓

FATHER
12. Name Francis C Bourdon
13. Birthplace Del

MOTHER
14. Maiden Name ? Stella Contag
15. Birthplace Brooklyn N.Y.

16 (a) Informant Francis C. Bourdon
(b) Address 17 Shipside Wilm. Del.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-2-47 (month) (day) (year)
(c) Cemetery or crematory Wilmington Del
Location

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Balt St.

19 (a) (Date received by registrar) (b) Registrar

VS 150

Beatrice Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 1947, at 740 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1947 to 10/31 1947 and that I last saw him alive on 10/31 1947

Immediate cause of death Hydrocephalus — Duration: life
Due to
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation 10/31/47
Major findings of operation: Congenital Malformation of Brain
Autopsy: Sara.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Hennick M.D.
Address JHH Date signed 11/1/47

J.H. Hennick X

G56539 A.C. 2-9317 BALTIMORE CITY HEALTH DEPARTMENT G56539
CERTIFICATE OF DEATH 1577 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Centre St
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Union Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Adelsberger

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-29-47

8. AGE: Years	Months	Days	If less than one day
—	—	3	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William G. Adelsberger
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine O'Leary
15. Birthplace Md.

16 (a) Informant Mother
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3/1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Hudson Mill Rd.

18 (a) Funeral director Henry Lee Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) (Date received by registrar) (b) Huntington Williamsville

NOV 5 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1 1947 at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1947 to 11-1 1947, and that I last saw him alive on 11-1 1947

Immediate cause of death Respiratory Failure — Duration 15 hours

Due to Meningocephalitis — Duration Life

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Beatty Jr. M. D.
Address Mercy Hosp Date signed 11-2-47

X

BALTIMORE CITY HEALTH DEPARTMENT ✓ G56540

G56540 **CERTIFICATE OF DEATH** 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Northern Parkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida B. Smith

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John W. Smith
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): August 30, 1867

8. AGE: Years: 80 | Months: 2 | Days: 0 | If less than one day: hr. min.

9. Birthplace: Baltimore County, Maryland (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Emanuel Anstine
13. Birthplace: Pennsylvania

MOTHER
14. Maiden Name: Elizabeth Markel
15. Birthplace: Pennsylvania

16 (a) Informant: D. Arthur Smith (Son)
(b) Address: 2901 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetey
Location: Eastern Avenue Balto: Co. Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) NOV 2 1947 (Date received by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, th 19 47 at M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to 10/30 1947 and that I last saw him alive on 10/29 1947

Immediate cause of death	Duration
Hypertension	
Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Ow Foltz M. D.
Address 5703 Harford Rd Date signed 10/31/47

X

G56541

BALTIMORE CITY HEALTH DEPARTMENT ✓ G56541
CERTIFICATE OF DEATH 164a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James N. Gray

3 (b) If veteran, name war None

3 (c) Social Security Account No. 213-01-2245

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen G. Hagan

6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) July 18th, 1908

8. AGE: Years 39 | Months 3 | Days 12 | If less than one day ##### hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Atlantic Supply Co

FATHER
12. Name James Gray
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ellen T. Parr
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Helen G. Gray--Wife
(b) Address 1845 N. Regester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 NOV 2 - 1947 (b) Huntington Williams
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1947, at 4 20 M

21. I certify that I took charge of the remains described above, held an Inq & Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suicide by hanging

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct 30, 1947 at 3 50 P.M.
(b) Where did injury occur? 1812 Rutland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hung self with an electric cord

23. Signature William J. McGrath M.D.
Medical Examiner.

Date signed Oct 30, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656542 — BALTIMORE CITY HEALTH DEPARTMENT — 656542 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 E. 27th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 E. 27th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patrick F. Lyms

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M. Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Sept. 15-1891

8. AGE: Years 56 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and State)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Patrick Lyms

13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen Cosgrove

15. Birthplace Ireland

16 (a) Informant Mrs Eliz Lyms

(b) Address 7 E. 27th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md.

18 (a) Funeral director Flynn & Flemming

(b) Address 1416 Light St.

19 (a) Date rec'd by Registrar 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31. 1947 at 3:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to Oct. 30 1947, and that I last saw him alive on Oct. 30 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 hrs.
Due to Arteriosclerosis & Hypertension	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry A. Kelly M. D.

Address 25 W. Lanvale St. Date signed 10/31/47

056543 440691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47F

Registered No. 056543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County.....
(c) City or town Norfolk. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3911 Granby St. Park Manor Apts (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Horace Ewell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ruth Ewell (OVER)
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) July 3, 1892

8. AGE: Years	Months	Days	If less than one day
5-5-	3	29	.....hr. .....min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Clerk U.S. Customs Service
11. Industry or business

FATHER: 12. Name Felix Ewell
13. Birthplace Va.

MOTHER: 14. Maiden Name Sarah Briggs
15. Birthplace Va.

16 (a) Informant Mrs. Horace M Ewell
(b) Address 3911 GRANBY ST - NORFOLK, Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 5 1947 (month) (day) (year)
(c) Cemetery or crematory Forest Lawn
Location Norfolk, Va

18 (a) Funeral director Harry H Witzke
(b) Address 4101 Edmondson Ave

19 NOV 3 1947 (b) Huntington Williams M.D. (Registered by registrar)

95 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 - 1947, at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29- 1947 to 11-2- 1947 and that I last saw him alive on 11-2- 1947

Immediate cause of death	Duration
Cardiac failure	15 MIN
Due to Chronic anoxia	6 MOS
Due to Obstruction of trachea by mediastinal tumor	12 MOS
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation NONE
of autopsy NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Milton Edgerton
Address Hopkins Hospital Date signed 11/3/47

X

G56544 ✓ G56544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw Place & Wilson St.
(c) Hospital or institution: Marlborough Apts. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY STEIGER.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Ida D. Steiger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1877.

8. AGE: Years	Months	Days	If less than one day
70	5	29	hr. min.

9. Birthplace Austria.
(Town, county, and state)
10. Usual Occupation Retired (?)
11. Industry or business

FATHER
12. Name Marcus Steiger,
13. Birthplace Austria.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Austria.

16 (a) Informant Mrs. Charles Adler, Jr.
(b) Address 2401 Ken Oak Road.

17 (a) Burial (b) Date thereof 11/3/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director David Sondheim & Son
(b) Address 1902 Eutaw Place.

19 (a) NOV 5 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1947 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1939 to Nov 1 1947 and that I last saw h[illegible] alive on Nov 1 1947.

Immediate cause of death	Duration
Uremia Pyelonephritis.	5 days
Due to Hypertension	15 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Levin M. D.
Address 1720 Eutaw Place. Date signed 11/4/47.

G56545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56545 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Light Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MATT SEXTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace RUSH, KY. CARTER Co. (Town, county, and state)

10. Usual Occupation MACHINE OPERATOR

11. Industry or business

FATHER
12. Name ALVA LEE SEXTON
13. Birthplace RUSH, KY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace RUSH, KY

16 (a) Informant MR & MRS DAVID MAPP
(b) Address 711 LIGHT ST -

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 5 47 (month) (day) (year)
(c) Cemetery or crematory RUSH CEMETERY
Location RUSH, KY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST. -30

19 (a) NOV 3 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1/47 19 , at 9:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Stark M.D. Medical Examiner.
Date signed 11/2/47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G56546

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3179 Fourth St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3179 Fourth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorathea Bowman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas L. Bowman
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) MAY 12, 1889

8. AGE: Years	Months	Days	If less than one day
58	7	17	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name George Fox
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Landabeck
15. Birthplace Germany

16 (a) Informant Jos. Thomas Bowman
(b) Address 3179 Fourth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 3 47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST -30

19 (a) NOV 3 - 1947 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/47 19 , at 11 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1947 to 10/29 1947 and that I last saw h[illegible] alive on 10/29 1947

Immediate cause of death Carcinoma of Kidney with general metastases

Duration
about 1 year

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation 6/10/47

Major findings of operation: Metastatic Carcinoma

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Cecil
Address 1712 Hanover St Date signed 11/1/47 M.D.

VS 150

656547 JL - 75509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. 656547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Hamilton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1889

8. AGE: Years	Months	Days	If less than one day
58	3	10	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Hamilton
13. Birthplace Md.

MOTHER
14. Maiden Name Georganna ?
15. Birthplace Md.

16 (a) Informant B. C. Hosp. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11 [illegible] 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) [illegible] (b) [illegible]
(Filed) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1947, at 2.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1942 to Oct. 28 1947, and that I last saw h er alive on Oct. 28 1947

	Duration
Immediate cause of death Congestive Failure	1 Wk
Due to Arteriosclerotic C. V. D.	yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Raymond Beadnam M. D.
Address Bal. City Hosp. Date signed 31 Oct 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G56548

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st St. & Hymen Pk. Dr.
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1m, 4d
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FIRST NAME Robert LAST NAME Cole

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Beatrice Cole
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1889

8. AGE: Years	Months	Days	If less than one day
58	8	26	hr. min.

9. Birthplace Charlottesville, Va.
(Town, county, and state)
10. Usual Occupation porter
11. Industry or business

FATHER
12. Name John Cole
13. Birthplace Charlottesville, Va.

MOTHER
14. Maiden Name Elizah ?
15. Birthplace Balto., Md.

16 (a) Informant [illegible] ERSON
(b) Address 1407 W. SARATOGA ST.

17 (a) Burial (b) Date thereof Nov. 6, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co., Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 6321 Dunid Hill Ave.

19 (a) NOV 3 - 1947 (b) Thomas Wellington Williams
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1947, at 12m M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1947, to Nov 1 1947, and that I last saw h. alive on Nov 1 1947.

Immediate cause of death	Duration
Adenocarcinoma, involving peritonia, liver, lung pancreas, spleen, stomach and sous diaphragm, primary site undetermined.	unk.
Due to	
Other Conditions Bronchopneumonia right lower lobe.	

(Include pregnancy within 3 months of death)
Date of operation Oct. 7, 1947
Major findings of operation: colostomy as above
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Glen E. Ogden M. D.
Address U.S. Marine Hosp. Date signed 11-2-47

656549

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. 656549

CERTIFICATE OF DEATH 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3318 Calvert Ste.
(c) Hospital or institution: Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Queen Annes
(c) City or town Centerville.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. FRED. W. Green

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife ALFRED M. GREEN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28/01

8. AGE: Years	Months	Days	If less than one day
45	10 11	26?	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Home wife.
11. Industry or business

FATHER
12. Name Winfield Webster
13. Birthplace Maryland

MOTHER
14. Maiden Name Stella Moore
15. Birthplace Maryland

16 (a) Informant Daughter
(b) Address Ruxton, Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 5-47 (month) (day) (year)
(c) Cemetery or crematory Churchfield
Location Centreville Maryland

18 (a) Funeral director Baetas Bros
(b) Address Centreville, Maryland

19 (a) Filed (State registrar) (b) Registered Nov 3 1947 (Local registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1947, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 1947 to 11/2 1947 and that I last saw h[er] alive on 11/2 1947.

Immediate cause of death Pulmonary embolus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 10/30/47
Major findings of operation: Ruptured U.U. disc.
of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 10-7-47 at ? M
(c) Where did injury occur? Centerville, Queen Anne, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? NO
(Specify type of place)
(e) Means of injury Fell down stairs

23. Signature John A. Fowler M. D.
Address Union Memorial Hosp. Date signed 11/2/47

Howard J. Mencken, M. D.

VS 150

G56550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G56550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3862 Dolfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Harrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Kligerman

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Aaron
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1892

8. AGE: Years	Months	Days	If less than one day
55	—	23	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hyman Shulick
13. Birthplace Russia

MOTHER
14. Maiden Name Brauda Malicki
15. Birthplace Russia

16 (a) Informant Mrs Aaron Kligerman
(b) Address 2405 Harrison Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Baltimore

18 (a) Funeral director Lazing Byers
(b) Address 5005 Park Heights Ave

19 NOV 3 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1947, at 3p M

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1947 to 10/31 1947, and that I last saw her alive on October 1947

Immediate cause of death: carcinoma of the pancreas — Duration 6 mos
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation April 24, 1947
Major findings of operation: Carcinoma of pancreas with ascites
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm B. Settle M.D.
Address 514 Medical Arts Bldg Date signed 11/3/47

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056551

LW 113510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 056551

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore & East Liverpool, O.
(If outside city or town limits, write RURAL and give county)
(d) Street No. 807 S. Broadway-510 Grant Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Austin Holt or Henry C. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25/1894

8. AGE: Years	Months	Days	If less than one day
53	7	3	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Smith (D)
13. Birthplace England

MOTHER
14. Maiden Name Mary Morris
15. Birthplace Ireland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Lemmon Street
18 (a) Funeral director J. F. Bakey Sons
(b) Address 1218 Light St.
19 (a) NOV 3 1947 (b) Thurlington Williams, M.D.
(Date rec'd by Local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28- 1947, at 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1947, to Oct. 28 1947, and that I last saw him alive on Oct. 28 1947.

	Duration
Immediate cause of death Pulmonary Tuberculosis, Far advanced	3 yrs
Due to	
Due to	
Other Conditions Chronic Myocarditis - Asthma	6 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Leigh W. Parker M. D.
Address B.C.H. Date signed 10-28-47

VS 150

X

Dr MacLaughlin 400 N Payson St. Ba 0498 10-12

056552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 056552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 238 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 238 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Music

3 (b) If veteran, name war

3 (c) Social Security Account No. 401-03-1703

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Mabel Music

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2nd 1905

8. AGE: Years	Months	Days	If less than one day
42	10	0	hr. min.

9. Birthplace Auxier, Kentucky
(Town, county, and state)

10. Usual Occupation Storedare

11. Industry or business Grain Piers

FATHER
12. Name Jack Music
13. Birthplace Auxier Ky

MOTHER
14. Maiden Name Cora Stevens
15. Birthplace Cliff Ky

16 (a) Informant Mrs. Mabel Music
(b) Address 238 N. Fulton Ave

17 (a) Removal (b) Date thereof 11/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Paintsville
Location Kentucky

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) NOV 3 1947 (b) Huntington West Virginia
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2nd 1947, at 5.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1947 to 11/2 1947 and that I last saw ~~him~~ her alive on 11/1 1947

Immediate cause of death	Duration
Bronchogenic Carcinoma	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D.C. MacLaughlin M. D.
Address 400 N. Payson St. Date signed 11/3/47

D.C. MacLaughlin X

G56553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

Registered No. G56553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raymes Ave & Hutaland St
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY F. SCHERER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Helen Scherer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11-1882

8. AGE: Years 65 | Months 0 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Henry Scherer

13. Birthplace Md.

MOTHER 14. Maiden Name Louise Lauterich

15. Birthplace Md.

16 (a) Informant Edmund C. Scherer

(b) Address 2810 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong

(b) Address 2707 W. North Ave

19 (a) NOV 3 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31, 1947, at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1947 to 10-31 1947 and that I last saw him alive on 10/31 1947.

	Duration
Immediate cause of death: Pulmonary Embolism	
Due to: Subacute Bacterial Endocarditis	
Due to: Rheumatic Cardiovascular-renal Disease	
Other Conditions: Latent Syphilis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Goldsborough

Address 300 W. North Ave Date signed M/D 11/1/47

VS 150

93c

G56554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56554

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2602 Jefferson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Holzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. C. Holzer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6-1868

8. AGE: Years	Months	Days	If less than one day
79	1	27	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name George Diehn
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Wm. C. Holzer
(b) Address 2602 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4-47 (month) (day) (year)
(c) Cemetery or crematory Schwartz & Co.
Location O'Donnell St.

18 (a) Funeral director John G. Mulloy
(b) Address 2334 Jefferson St.

NOV 3 1947 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2 1947, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27th 1947 to Nov 1st 1947 and that I last saw h alive on 11/1st 1947.

Immediate cause of death	Duration
Cardiac failure	4 days
Due to Cardio Vascular disease	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Tauber M. D.

Address 100 N. Mulloy Date signed 11/3/47

VS 150

X

G56555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G56555

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or Institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3223 Fallstaff Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Goldman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (State or county, and state)

10. Usual Occupation Clothing Mfg

11. Industry or business

FATHER
12. Name Solomon
13. Birthplace Russia

MOTHER
14. Maiden Name Rose
15. Birthplace Russia

16 (a) Informant Anna Goldman
(b) Address 3223 Fallstaff Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mill Road

18 (a) Funeral director Jack Levin Inc
(b) Address 7166 Eutaw Place

19 (a) NOV 3 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1947, at 1:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1947 to 11-2 1947, and that I last saw him alive on 11-2 1947

Immediate cause of death: Carcinomatosis — Large Bowel Obstruction — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman E. Zumberg M. D.
Address Sinai Hospt. Date signed 11-2-47

VS 150

X

G56556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56556

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Light St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Pivarnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1872

8. AGE: Years 75 (87) | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant David Pivar
(b) Address 3701 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-47 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jacob Lewis Inc
(b) Address 2160 Eastern Place

19 (a) NOV 3 - 1947 (Date rec'd by registrar) (b) Signature for Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3-1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1947 to 11/3 1947, and that I last saw h[illegible] alive on 11/3 1947.

Immediate cause of death Arteriosclerotic heart disease — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Flom
Address 3215 Eastern Ave Date signed 11/3/47 M.D.

Charles Flom +

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 56557

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 236 S. Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 236 S. Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME antonina Moniewska

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife Stanley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 79			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Kalinowski
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Peter Moniewski
(b) Address 830 S. Kenwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Balto. city

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) NOV 3 - 1947 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1947, at 10 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1945 to Nov. 1 1947 and that I last saw her alive on Nov. 1 1947.

Immediate cause of death	Duration
Myocardial insufficiency	2 days
Due to Chronic myocarditis	2 yrs
Due to Arterial Deficiency	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John V. Bzostowski M. D.
Address 1802 Eastern Ave Date signed 11-3-47

V S 150

G56558 G56558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampstead Ave
(c) ~~Hospital~~ or institution: Pine Ridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Hollen Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Hannah Marie Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John E. Shipley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1865

8. AGE: Years 82 | Months 7 | Days 18 | If less than one day: hr. min.

9. Birthplace Wexford, Ireland (town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name Thomas Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Markey
15. Birthplace Ireland

16 (a) Informant Franklin Bjce
(b) Address Richmond, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Loraine Presbyterian
Location Donnington, Balto, Md

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) Nov 3 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1st 1947, at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1947 to Nov 1st 1947, and that I last saw her alive on October 28 1947.

	Duration
Immediate cause of death Uremia and Acidosis	2 wks
Due to Interstitial chronic nephritis	7 yrs
Due to Generalized arteriosclerosis	7 yrs
Other Conditions Fracture, neck of left femur	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/12
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept 21 A.D. 1947 at 7 P M
(c) Where did injury occur Elevator Theatre Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No (Specify type of place)
(e) Means of injury Slipped + fell on street

23. Signature Frederick J. Voelker M. D.
Address 6100 York Road Date signed Nov 1 1947

VS 150 11/6/47 Mary E. Merrill MD X

G56559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56559 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Dakota General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Chesapeake Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver Lawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Widow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace NC (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Clarence Powell
(b) Address 3334 Fairfield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem Co
Location Md.

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) (Date received by registrar) (b) [illegible] Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 1947, at 5P.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Royer M.D.
Medical Examiner.
Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given if possible. Be sure to state the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the

656560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 656560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Ln.
(c) ~~Hospital or institution~~: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Giza

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Wid.

6 (b) Name of husband or wife Josephine Giza
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1873

8. AGE: Years	Months	Days	If less than one day
74	6	6	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Stella Sadus 1200 Valley Ln
(b) Address

17 (a) Burial (b) Date thereof Nov. 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St

19 (Date rec'd by registrar) NOV 3- 1947 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29th 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1947 to Oct 29 1947, and that I last saw him alive on Oct 29 1947

Immediate cause of death	Duration
Edema of Lungs	3 days
Due to Chronic Myocarditis	3 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M.D.
Address 1631 - E. North Ave Date signed 10/30/47 M. D.

VS 150

656561

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH / 46F

Registered No. 656561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2610 Greenmount Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Greenmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAVERIA ANELLO

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Ath Home
11. Industry or business

FATHER
12. Name Sam. Plo.
13. Birthplace Italy

MOTHER
14. Maiden Name (?)
15. Birthplace (?)

16 (a) Informant Mrs. Angela Liberto
(b) Address 2610 Greenmount Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) NOV 3 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1st. 1947, at 4:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 August 1947 to 1 Nov. 1947, and that I last saw h.e.r. alive on 31 Oct 1947

Immediate cause of death Carcinoma of gall bladder with metastasis — Duration about 2 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation (1) 17 Jan '46 (2) 22 Aug 47
Major findings of operation: (1) - Carcinoma of gall bladder (2) Surg. mass of carcinoma in abdomen
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A Krahl Jr. M. D.
Address 20 E. Preston St Baltimore Date signed 3 Nov 1947

VS 150

G56562 B.C.# 9-80313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. G56562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town 820 E. 22nd ST. BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY JAJEANNE BUCKLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/17/43

8. AGE: Years	Months	Days	If less than one day
4	3	15	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name ALFRED BUCKLEY, JR
13. Birthplace BALTO -

MOTHER
14. Maiden Name DOROTHY (?)
15. Birthplace

16 (a) Informant HOSP. RECORDS - ST. JOSEPHS
(b) Address 1400 N. CAROLINE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-4-47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL CEM.
Location CITY.

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND ST.

19 (a) NOV 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1 1947 at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 1947 to 11/1 1947 and that I last saw h[illegible] alive on 11/1 1947

Immediate cause of death	Duration
TUBERCULOUS MENINGITIS	
Due to PULMONARY (MILIARY)	
Due to TUBERCULOSIS	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry J. Houska M.D.
Address St. Jos. Hosp. Date signed 11/1/47

VS 190

G56563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G56563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before any copies are made. Do not leave any items unanswered. Where there is no entry, write "None," "Unknown," or "Does not apply," as the case may be. Please report causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that the cause of death is stated in such terms that a definite disease may be assigned as the principal cause of death. Indefinite or unsatisfactory terms, such as "Heart Failure," "Kidney Trouble," "Septicemia," "Pneumonia," "Tuberculosis," "Cancer," "Hemorrhage," "Accident," "Fracture," "Burns," "Drowning," "Shock," "Senility," "Old Age," "Infection," "Blood Poisoning," "Convulsions," "Paralysis," "Uremia," "Asphyxia," "Exhaustion," "Coma," "Abscess," "Gangrene," "Ulcer," "Tumor," "Childbirth," "Abortion," "Stillbirth," "Premature Birth," "Congenital Debility," "Malformation," "Marasmus," "Inanition," "Cachexia," "Debility," "Weakness," "Natural Causes," "Multiple Causes," "Complications," "Contributory," "Meningitis," "Hepatitis," "Nephritis," "Cystitis," "Colitis," "Enteritis," "Gastritis," "Peritonitis," "Appendicitis," "Arthritis," "Rheumatism," "Neuritis," "Neuralgia," "Myocarditis," "Endocarditis," "Pericarditis," "Phlebitis," "Thrombosis," "Embolism," "Aneurism," "Arteriosclerosis," "Cirrhosis," "Pyelitis," "Pyelonephritis," "Cellulitis," "Pleurisy," "Bronchitis," "Laryngitis," "Pharyngitis," "Tonsilitis," "Otitis," "Mastoiditis," "Sinusitis," "Abnormality," "Deformity," "Lesion," "Disease," "Disorder," "Failure," "Insufficiency," "Obstruction," "Perforation," "Rupture," "Inflammation," "Suppuration," "Necrosis," "Septicemia," "Toxemia," "Pyemia," "Hypostasis," "Edema," "Anemia," "Hemorrhage," "Shock," "Syncope," "Collapse," "Coma," "Delirium," "Convulsions," "Paralysis," "Hemiplegia," "Aphasia," "Apoplexy," "Cerebral Hemorrhage," "Cerebral Thrombosis," "Cerebral Embolism," "Cerebral Softening," "Cerebral Abscess," "Cerebral Meningitis," "Cerebral Tumor," "Cerebral Aneurism," "Cerebral Arteriosclerosis," "Cerebral Hypostasis," "Cerebral Edema," "Cerebral Anemia," "Cerebral Hemorrhage," "Cerebral Shock," "Cerebral Syncope," "Cerebral Collapse," "Cerebral Coma," "Cerebral Delirium," "Cerebral Convulsions," "Cerebral Paralysis," "Cerebral Hemiplegia," "Cerebral Aphasia," "Cerebral

G56564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G56564

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 S. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Smiglewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-9687

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1885

8. AGE: Years 62 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Labor.

11. Industry or business

FATHER 12. Name Martin Smiglewski
13. Birthplace Poland

MOTHER 14. Maiden Name Antonia Chojnowski
15. Birthplace Poland

16 (a) Informant Mrs Rose Smiglewski
(b) Address 722 S. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 705 S Ann st

19 NOV 3 19[illegible] (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st 1947 at 1.0 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular - Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L Rogen M.D. Medical Examiner.
Date signed 11-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be filled in. Be sure to give the causes of death clearly and legibly. Be correct age is especially important. Physicians: please write the

VS 131

656565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 656565

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4105 Raspe Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4105 Raspe Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET HAMMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife August Hammer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1884

8. AGE: Years	Months	Days	If less than one day
63	8	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Clara Kunze
(b) Address 4105 Raspe Ave.

17 (a) Burial (b) Date thereof 11 4 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S Wolfe St. Balto. Md.

19 (a) [illegible] (b) Huntington Williams, M.D.
(Signature of Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1947 at 7:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1941 to Nov. 1 1947 and that I last saw her alive on Oct. 28 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	1/2 hour
Due to Carcinoma of Uterus	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D., M. D.
Address 2413 E Monument St Date signed

X 11/3/47

G56566 BC# 4-88784 BALTIMORE CITY HEALTH DEPARTMENT G56566

CM. 114810 CERTIFICATE OF DEATH 30 F Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1332 N. Stricker ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roland Nathaniel Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-21-47

8. AGE: Years	Months	Days	If less than one day
	2	10	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Roland Lancaster
13. Birthplace MD.

MOTHER 14. Maiden Name Mary V. Smith
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/47 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Preston ave

19 (a) NOV 3 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 - 1947, at 3.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 - 1947 to 10-31 - 1947, and that I last saw h im alive on 10- 31 - 1947

	Duration
Immediate cause of death: Pneumonia	4 days
Due to: Pertussis	10 days
Due to:	
Other Conditions: Congenital Syphilis (Include pregnancy within 3 months of death)	2 mos.

Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian P. Coffin M. D.
Address Balto. City Hosps. Date signed 1 Nov '47

9

565567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

MA 104 / 1 31a

565567 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1636 Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Mallay

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Laurence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1879

8. AGE: Years 68 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Laurence A. Mallay
(b) Address 1636 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelly
(b) Address 1302 Pennsylvania Ave

19 NOV 3 - 1947 (Date rec'd by registrar) (b) Washington Wells Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1 47 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 47 to 11/1 1947; and that I last saw [illegible] alive on 19

Immediate cause of death Cer. Hemorrhage

Due to Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burkett M. D.
Address 36 D. St. Date signed 11/1 47

VS 150

G56568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56568

PLEASE WRITE PLAINLY, with CHEMICAL PENCIL or PEN and INK. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, whether married, widowed, or divorced, and date of birth, whether birthplace and residence of informant. Please answer all questions. If any question is not applicable, write NONE. Where exact information is not known, approximate date, age, or location may be given. Be sure that the cause of death is stated in such terms as to show the disease, injury, or complication which caused death, and not the mode of dying, such as heart failure, asphyxia, or anemia. Indefinite or unsatisfactory terms of classification will be returned for correction. Operations should be mentioned only when performed for the disease causing death. Violent deaths must be reported to the Coroner before burial. Sign certificate and return promptly to the Registrar.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 1818 Norman St
(c) Hospital or institution: LORMAN
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Norman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Henry McCoy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife Ella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1878

8. AGE: Years	Months	Days	If less than one day
59 SMT	4	16	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Geo. W. McCoy
13. Birthplace Va

MOTHER
14. Maiden Name Maggie Robinson
15. Birthplace Va

16 (a) Informant Eva Stewart
(b) Address 1818 Lorman St

17 (a) Burial (b) Date thereof 11/3/49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pressman St

19 (a) (Registrar) (b) Huntington Williams, M.D.
Registrar

NOV 3 - 1949

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2 1949 at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Schmuhl M.D.
Medical Examiner.
Date signed 11/3/49

BC-C 15887

056569

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1062

Registered No. 056569

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 N. Bond St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME JEANIE MAE WHITE

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex Female | **5. Color or race** Colored | **6 (a) Single, married, widowed, or divorced.**

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8/15/47

8. AGE: Years | Months 2 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Roosevelt White
13. Birthplace Rock Hill S. C.

MOTHER
14. Maiden Name Margret Parham
15. Birthplace Selma Va

16 (a) Informant Roosevelt White
(b) Address 628 N. Bond St

17 (a) Burial **(b) Date thereof** Nov. 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ft Calvary Am
Location Brooklyn Md

18 (a) Funeral director Clary O. Wilson
(b) Address 1010 Belnord ave

19 (a) NOV 3 - 1947 **(b)** Huntington Williams, M.D.
(Date filed by registrar) Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Where none, so state. Do not use ditto marks. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1947, at 7.50 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Acute tracheobronchitis
Asphyxia due to aspiration of mucus
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10-30-47

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X

656570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V163M

Registered No. 656570

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3522 Elmley Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Was known as Charles Henry Scharoun
CHARLES H. SCHAROUN

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-2531

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband~~ or wife Geneva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1905

8. AGE: Years 42 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name Frank H. Scharoun
13. Birthplace Maryland

MOTHER 14. Maiden Name Louise Anderson
15. Birthplace England

16 (a) Informant Mrs. Frank Scharoun
(b) Address 3522 Elmley Avenue

17 (a) Burial (b) Date thereof 11/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Hartford Rd

18 (a) Funeral director John G. Moran
(b) Address 3060 E. Balt. St

19 NOV 3 - 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1947, at 11 A.M. 45

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/1/47 at A.M.
(b) Where did injury occur? Highland Ave. & Fayette St.
(c) Did injury occur at home, on farm, industrial place or public place? Garage While at work? No
(d) Means of injury Carbon Monoxide Fumes

23. Signature Earl [illegible] M.D.
Medical Examiner.

Date signed 11/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every answer must be full and complete. Do not use ditto marks. Do not abbreviate. Write out the full name and address. Do not leave any item unanswered. Write "None," "Unknown," or "Not Applicable," where necessary. Be sure to fill in items 19 and 20. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

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656571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓53

Registered No. 656571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 Union Avenue
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Union Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Harriett V. Mahaffey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18-1874

8. AGE: Years 73 | Months — | Days 13 | If less than one day hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name James D. Mahaffey

13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Dinsmore

15. Birthplace Pennsylvania

16 (a) Informant Mrs. Helen C. Mahaffey

(b) Address 1410 Union Avenue

17 (a) Removed to Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4-1947 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Philadelphia, Pennsylvania

18 (a) Funeral director Dwyer Funeral Home

(b) Address 3631 Falls Road

19 (a) NOV 3 - 1947 (Date rec'd by registrar) (b) Huntington-Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1- 1947, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Nov 1 1947, and that I last saw her alive on Oct. 31 1947.

Immediate cause of death	Duration
Uremia	2 wks
Due to Nephritis acute	
Due to	
Other Conditions Multiple Contusions of Jaw (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. D. Dwyer M. D.

Address 1152 Eager St Date signed 11-4-47

V S 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

365572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4344 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4344 Falls Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence E. McComas

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: D. Naoma McComas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4-1886

8. AGE: Years	Months	Days	If less than one day
61	3	28	hr. min.

9. Birthplace Baltimore Co. Maryland
(Town, county and state)
10. Usual Occupation Filling Station Operator
11. Industry or business

FATHER
12. Name George F. McComas
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Martin
15. Birthplace Maryland

16 (a) Informant Mrs. D. Naoma McComas
(b) Address 4344 Falls Road

17 (a) Burial (b) Date thereof Nov. 4-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) NOV 3 1947 (b) Huntington, Md. Registrar
(Not to be registered)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2- 1947, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Nov 2 1947, and that I last saw h alive on Nov 2 1947.

Immediate cause of death	Duration
Pulmonary tuberculosis	7.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lawrence J. Kenneally M. D.
Address 344 Falls Rd Date signed 11-3-47

X

G56573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G56573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2915 Overland Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2915 Overland Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John Richard Tynney

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Alice W. Tynney
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 13 1881
8. AGE: Years 65 | Months 10 | Days 19 | If less than one day: hr. min.
9. Birthplace Baltimore City, Md. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name William Tynney
13. Birthplace Ireland.

MOTHER
14. Maiden Name Sarah Carbon
15. Birthplace Ireland

16 (a) Informant: Mrs. Sarah Irwin
(b) Address 2915 Overland Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 5-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 3031 Falls Road
19 NOV 3 1947 (Date rec'd by registrar) (b) Huntington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 November 1947, at 9.25 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 30 July 1947 to 2 Nov. 1947, and that I last saw h.em alive on 1 Nov. 1947

	Duration
Immediate cause of death: Widespread Metastasis	
Due to: Carcinoma Head of Pancreas	3 Yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John C. Colmore M. D.
Address 1402 Hanover St Date signed 2 Nov 47

VS 150

G56574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56574

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 E. Bishop's Road
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) About 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 E. Bishop's Road
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country --------

3 (a) FULL NAME Anna M. Landers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age --years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
About 70	---	---	--hr. --min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation ----------
11. Industry or business ----------

FATHER
12. Name James Landers
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Caroline Gee
15. Birthplace Ireland

16 (a) Informant S. R. Mears
(b) Address 805 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meades and Son
(b) Address 805 N. Calvert Street

19 (a) NOV 3 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1947 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 19--, to Nov 1 1947, and that I last saw her alive on Oct 31 1947.

Immediate cause of death	Duration
Cardiac dilatation	2 days
Due to Chronic Valvular Heart Lesion + Myocarditis	Indefinite
Due to (2)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. St. Maynard M. D.
Address 115 S Eager Date signed 11/3/47

X

656575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 656575

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2252 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Pyatt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1940

8. AGE: Years	Months	Days	If less than one day
7			hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Morris Pyatt
13. Birthplace S. C.

MOTHER
14. Maiden Name Evelyn Pyatt
15. Birthplace S. C.

16 (a) Informant Morris Py
(b) Address 2252 Madison ave

17 (a) Burial (b) Date thereof 11/3/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Georgetown
Location South Carolina

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Pennsylvania ave

19 (a) NOV 3 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Nov 1947, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, (Spontaneous subarachnoid)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 2 Nov 47

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0556576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937 D

Registered No. 0556576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4403 Fredrick Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 Fredrick Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bro. Anastaisius C.F. X. (Joseph H. Glasmier)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1862

8. AGE: Years 85 | Months 8 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Bro Victorian
(b) Address 4403 Fredrick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Edmonson Ave

18 (a) Funeral director Charles F. Evans & Son
(b) Address 118 W Mt. Royal Ave.

19 (a) NOV 2 - 1947 (Date received by registrar) (b) Huntington Wilkinson Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1947, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1947 to Nov 1 1947 and that I last saw h[illegible] alive on Nov 1 1947.

Immediate cause of death	Duration
Pulmonary Oedema.	
Due to Myocarditis Chronic Pulmonary Emphysema	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C Nitsely M. D.
Address 2151 W Lanvale ave Date signed 10/24/47

G565577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No. G565577

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Md. General Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4104 ALAMEDA BLVD. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE MILLER

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife John H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-2-1855

8. AGE: Years	Months	Days	If less than one day
92	7	0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Hammer
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Strull
15. Birthplace Germany

16 (a) Informant Miss MARY MILLER
(b) Address 4104 ALAMEDA BLVD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4700 Old Frederick Rd.

18 (a) Funeral director John J. Gorsuch & Son
(b) Address 901-07 Hollins St.

NOV 3- 1947 (Date rec'd by registrar) (Huntington Williams, M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2 1947, at 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1947, to 11/2 1947, and that I last saw her alive on 11/2 1947.

	Duration
Immediate cause of death CARDIAC FAILURE	
Due to AURICULAR FIBRILLATION	
Due to	
Other Conditions FRACTURE OF NECK OF LEFT FEMUR (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/1
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 10/24/47 at 11 AM M
(c) Where did injury occur? BALTIMORE (City or town), MD (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? No
(e) Means of injury Pt. Fell At Home While Unattended
23. Signature Paul G. Ward
Address Md. Gen. Hosp. Date signed M. 11 D. 2/47

VS 150

Paul G. Ward M.D. 11/3/47

656578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. 656578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lafayette & John St.
(c) Hospital or institution: Women Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince Georges
(c) City or town Berwyn
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Maher

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1st 1866

8. AGE: Years	Months	Days	If less than one day
80	11	11/30	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation House Work
11. Industry or business at home

FATHER
12. Name John Maher
13. Birthplace Ireland

MOTHER
14. Maiden Name Anne Fitzpatrick
15. Birthplace Baltimore Md.

16 (a) Informant Miss Josephine M. Maher
(b) Address Daniel Ave Berwyn Md

17 (a) Burial (b) Date thereof 11/4/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Augustine Cem
Location Elkridge Md.

18 (a) Funeral director Tobell Company & Son
(b) Address 900-02 Hollins St.

19 (a) NOV 5 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1st 1947 2.30 P M

21. I certify that I took charge of the remains described above, held an Aug & Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Coronary Occlusion
Due to Chronic Myocarditis

Other Conditions Chronic Bronchitis.
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kelbach M.D.
Medical Examiner.
Date signed Nov 1st 1947

VS 151

Please write plainly, preferably in ink. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

56579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(47)

Registered No. 56579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 E. Cross
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 E. CROSS ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES N. JONES

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife CORA ELIZABETH (ECKER)
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) FEB. 3, 1880

8. AGE: Years	Months	Days	If less than one day
67	8	26	....hr. ....min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation COMM. MERCHANT
11. Industry or business

FATHER
12. Name CHARLES W. JONES
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ANN A. WOOLFORD
15. Birthplace BALTIMORE, MD.

16 (a) Informant CHARLES N. JONES, JR.
(b) Address 103 E. CROSS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 4 47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK ROAD

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST -30

19 NOV 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1947, 7A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947, to Nov 1 1947. and that I last saw h[illegible] alive on Nov 1 1947.

Immediate cause of death	Duration
Pulmonary Hemorrhage	1 hour
Due to Carcinoma of R Lung (Right - primary)	6 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Miller M.D. M. D.
Address 1211 S Clearfield Date signed

VS 150

X 11/3/47

056580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 056580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1062 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Preston Edmonds

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No. 220-24-8877

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Wid.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1898

8. AGE: Years 49 | Months 5 | Days 4 | If less than one day ___ hr. ___ min.

9. Birthplace St. Louis, Mo.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business Veteran

FATHER
12. Name Lester Edmonds
13. Birthplace Mo.

MOTHER
14. Maiden Name Louisa Kern
15. Birthplace Miss.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Ave.

18 (a) Funeral director H. Hamp H. Wight
(b) Address 4101 Edmondson Ave.

19 NOV 3 1947 (Date rec'd by Registrar) (Signature) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1947, at 6:12A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1947, to Nov. 3 1947, and that I last saw h im alive on Nov. 3 1947.

	Duration
Immediate cause of death Thrombosis left vertebral artery	1-2 days
Due to	
Due to	
Other Conditions Hypertensive cardio-vascular disease with myocardial hypertrophy (Include pregnancy within 3 months of death)	5 yrs

Date of operation?
Major findings of operation
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stuart M. Sessoms
Stuart M. Sessoms. Asst. Surgeon M.D.
Address US Marine Hospital Date signed 11/3/47

V S 150

99

G56581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G56559 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 E. 33rd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN C. WILLS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Thomas H. Wills
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1891

8. AGE: Years	Months	Days	If less than one day
56	2	20	hr. min.

9. Birthplace Elizabeth, N. J.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Joseph Callahan
13. Birthplace New York, N. Y.

MOTHER
14. Maiden Name Sarah Mallon
15. Birthplace Ireland

16 (a) Informant Mr. Jack Wills
(b) Address 10 E. 33rd St.

17 (a) Removal (b) Date thereof 11/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Evergreen Cem.
Location Elizabeth, N. J.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

(a) Date received NOV 3 1947 (b) registrar [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1947, at 1:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1947 to 11/2 1947 and that I last saw h[illegible] alive on 11/2 1947.

Immediate cause of death Cerebral hemorrhage — Duration ?
Due to Carcinoma of the lung
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury MUSCAT ROYD

23. Signature George W. Mountjoy Jr. M. D.
Address 1114 St. Paul St. Date signed 11/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G56582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56582 Registered No. 1312a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 N 24th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 N. 24th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada L Spencer

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Sngl

6 (b) Name of husband or wife Cancel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day: hr.	min.
about 68				

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business Ret.

FATHER
12. Name Daniel Spencer
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Rachel Bunce
15. Birthplace Norfolk Va Md

16 (a) Informant Miss Estelle Stormont
(b) Address 2401 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 4 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Boyd & Greenmount Aves

18 (a) Funeral director Wilson Co Inc
(b) Address 1210 Park Ave

19 (a) NOV 4 - 1947 (Date rec'd by registrar) (b) Lucretia Von Hollingsworth, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1947 at 6 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27 1947 to Nov. 1 1947 and that I last saw her alive on Oct. 31 1947.

Immediate cause of death	Duration
Uremia	5 days
Due to Chr. Int. Nephritis	8 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer L. Todd M. D.
Address 2108 St Paul St Date signed 11/3/47

VS 150

G56583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G56583

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 N. Elmwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Walbrecher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Virgie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1886

8. AGE: Years 61 | Months 0 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. (town, county, and State)

10. Usual Occupation Superintendent

11. Industry or business Calvert Steamship Corp

FATHER 12. Name Gustav Walbrecher

FATHER 13. Birthplace Balto

MOTHER 14. Maiden Name Kath. Miller

MOTHER 15. Birthplace Balto.

16 (a) Informant Mrs. Virgie Walbrecher

(b) Address 1315 N. Elmwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4 47 (month) (day) (year)

(c) Cemetery or crematory Woodland Mem

Location Taylor Ave

18 (a) Funeral director L. Heckman & Son

(b) Address 6067 Harford Rd

19 (a) Nov 4 1947 (Date rec'd by reg.) Huntington Hilliard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1-47 19..., at 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29-47 19... to 11-1 1947. and that I last saw h[illegible] alive on 10-31-47 19...

Immediate cause of death: Intestinal Obstruction — Duration

Due to: Carcinoma

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 10/4/47 & 10/23/47

Major findings of operation: Intestinal Obst.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Powell Jr. M. D.

Address [illegible] Date signed 11-1-47

VS 150

G56584 ae.* 7-81076 BALTIMORE CITY HEALTH DEPARTMENT G56584

CERTIFICATE OF DEATH ✓108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714- Carswell St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714- Carswell Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES R. CORNWELL Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 11, 1943

8. AGE: Years	Months	Days	If less than one day
3	11	22	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James R. Cornwell, Sr.
13. Birthplace Md

MOTHER
14. Maiden Name Katherine Hiltz
15. Birthplace Md.

16 (a) Informant Katherine Cornwell
(b) Address 1636 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 6009 Harford Road

19 NOV 4 - 1947 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1947, at 11.30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
* Lobar pneumonia
Mesenteric adenitis
Acute splenic tumor
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryer M.D. (Medical Examiner.)
Date signed 11-3-47

VS 151

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

056585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. C56585

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD ARRINGTON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Isabelle Arrington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1908

8. AGE: Years 39 | Months 10 | Days 2 | If less than one day 23 hr. min.

9. Birthplace N.C. Nash. Co.
(Town, county, and state)

10. Usual Occupation mechanic

11. Industry or business Garage

FATHER
12. Name Haywood Arrington
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Person
15. Birthplace N.C.

16 (a) Informant Mrs Isabelle Arrington
(b) Address 1608 Madison ave. City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/47 (month) (day) (year)

(c) Cemetery or crematory Nashville, N.C.
Location Nashville, N.C.

18 (a) Funeral director Williams & Chatman

(b) Address 1701 McCullah St.

19 NOV 4 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1947, at 6.40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-47 at 9.30 a. M. 14/2
(b) Where did injury occur? 1608 Madison Ave. Balto. Md
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell to floor at home

23. Signature Earl L. Kaylor M.D.
Medical Examiner
Date signed 11-4-47

ORITA L. CHANCE

G56586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 F

Registered No. G56586

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3971 Brooklyn Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ORita L. Chance

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: BLANCHARD W.

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 5/2/98

8. AGE: Years 49 | Months 6 | Days - | If less than one day hr. min.

9. Birthplace: CECIL. Co. MD. (Town, county, and state)

10. Usual Occupation: STATISTICIAN

11. Industry or business

FATHER
12. Name: ALBERT J. RUSSELL
13. Birthplace: CECIL. Co. MD

MOTHER
14. Maiden Name: MARY E. COLE
15. Birthplace: CECIL. Co. MD

16 (a) Informant: LEONARD J. RUSSELL
(b) Address: 1519 PATAPSCO ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 6 47 (month) (day) (year)
(c) Cemetery or crematory: GLEN HAVEN
Location: RITCHIE HIGHWAY

18 (a) Funeral director: JOHN F. DENNY, INC
(b) Address: 715 LIGHT ST. -30

19 (a) NOV 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1947 at 6 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Carbolic acid poisoning

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-2-47 at ? A. M.
(b) Where did injury occur? 3971 Brooklyn ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Ingesting of Carbolic acid

23. Signature: Carl A. Ryder M.D. Medical Examiner
Date signed 2 Nov 47

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. 56587

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Age correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4356 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4356 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isadore Gamerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hannah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 84 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Paul
13. Birthplace Russia

MOTHER
14. Maiden Name Frena
15. Birthplace Russia

16 (a) Informant Hannah Gamerman
(b) Address 4356 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 (a) NOV 4 - 1947 (Date rec'd by registrar) (b) Thurlington Hollander, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3-1947 at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21, 1947, to Nov. 3 1947, and that I last saw h[illegible] alive on Nov. 3 1947

Immediate cause of death
Coronary Occlusion

Due to Generalized Atherosclerosis

Due to

Other Conditions Mitral Insufficiency and Stenosis, Arthritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Simon
Address 14 S. N[illegible] Ave Date signed 11/4/47

656588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

656588 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2928 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian A. Shearer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1880

8. AGE: Years 67 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Art Needlework-retired 6 yrs
11. Industry or business

FATHER
12. Name William Shearer
13. Birthplace Scotland

MOTHER
14. Maiden Name Agnes Carr
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Grace Shearer
(b) Address 2928 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Middendorf & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 4- 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1947, at 10/30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945 to Nov. 2 1947 and that I last saw h[illegible] alive on Nov. 2 1947

Immediate cause of death: Myocarditis, Chronic — Duration 2 yrs.
Due to Arteriosclerosis — Duration not known
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Sinton M. D.
Address 2824 St. Paul St. Date signed

VS 150

656589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1-61

Registered No. 656589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave.
(c) Hospital or institution: Wheeler Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Avon Apts., 6 E. Read St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Phoebe J. Longfellow

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Frank H. Longfellow
6 (c) If alive, give age years

7. Birth ~~registered~~ (mo., day, yr.) Nov. 15, 1878

8. Age: Years 68 | Months 11 | Days 17 | If less than one day hr. 17 min.

9. Birthplace Trappe, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name George M. Jenkins
13. Birthplace Talbot County, Md.

MOTHER
14. Maiden Name Annie Mallelieu
15. Birthplace Talbot County, Md.

16 (a) Informant Frank H. Longfellow, Jr.
(b) Address St. Michael's, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Whitehall & Sons, Inc.
(b) Address 1900 Eutaw Place

NOV 4 - 1947 (Date rec'd by Registrar) (By) Thomas Jones Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1947 at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Nov 2 1947 and that I last saw her alive on Nov 2 1947

Immediate cause of death: Cerebral Thrombosis — Duration: 3 days

Due to: Arterio-Sclerosis — Duration: Gradual

Due to: Hypertension — Duration: "

Due to: Old Cerebral Lues — Duration: "

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Healy, M.D.
Address 1403 Park Ave. Date signed 11/3/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G56590 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 North Broadway
(c) Hospital or institution: **********
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore city (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 North Broadway (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE MAY WALDMAN

3 (b) If veteran, name war, ********
3 (c) Social Security Account No. ********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: Single
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1880

8. AGE: Years	Months	Days	If less than one day
66	11	22	********** hr. ..... min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business: At Home

MOTHER / FATHER
12. Name: Henry Clay Waldman
13. Birthplace: Baltimore Maryland
MOTHER
14. Maiden Name: Maria Allen
15. Birthplace: Baltimore Maryland

16 (a) Informant: Miss Laura V. Waldman
(b) Address: 803 North Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4-47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Parkville, Maryland

18 (a) Funeral director: F. B. Wippert & Son
(b) Address: 1300 Eutaw Place

NOV 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 1st 1947, at 5:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 24, 1946 to November 1, 1947 and that I last saw h[illegible] alive on November 1, 1947

Immediate cause of death: Cardiac Dilatation and Insufficiency — Duration: 1 Day
Due to: Aortic Insufficiency — Duration: 3 Years
Due to: Chronic Interstitial Nephritis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Albert Eisenberg M.D.
Address: 2025 E. North Ave. Date signed: 11/1/47

VS 150

Dr. Eisenberg X

056591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 056591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 670 W. Saratoga
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 670 W. Saratoga (If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Henson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Boney Lipscomb
(b) Address 1 Pine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

NOV 4 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1/47 19 , at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Ins death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 11/2/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C56592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C56592

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Camel Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MACK WILLIS - ELMER SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-12-3611

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	27	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name mac Willis
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Virginia

16 (a) Informant Daisy Page
(b) Address 614 ½ Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) NOV 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1947, at 12.15 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D. Medical Examiner.
Date signed 11-3-47

656593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. 656593

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden St. - Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 So. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John (Adam) Krawczynski, (Jr.)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 16, 1921

8. AGE: Years	Months	Days	If less than one day
26	7	17	..... hr. ..... min.

9. Birthplace Baltimore, Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Potter

FATHER
12. Name John (Adam) Krawczynski,
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Katherine Sadowski
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. John (Adam) Krawczynski
(b) Address 320 S. Patterson Park Ave

17 (a) Burial (b) Date thereof 11/5/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Route

18 (a) Funeral director M. J. Radasky & Sons
(b) Address 1808 Eastern Ave

19 (a) NOV 4 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1947, at 4:57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1947, to Nov. 2 1947, and that I last saw h[illegible] alive on Nov. 2 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Marked Cardiac Decompensation	
Due to Rheumatic Heart Disease	
Other Conditions Mitral Stenosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Bu[illegible] M.D.
Address Md. Gen'l Hosp. Date sig[illegible] 11/4/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 056594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution:
Home For The Aged Penn. D
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agatha Ernst

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1861

8. AGE: Years	Months	Days	If less than one day
86	9	5	hr. min.

9. Birthplace Germany
(Town, county, and State)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Ernst
13. Birthplace

MOTHER
14. Maiden Name Teresa —
15. Birthplace

16 (a) Informant Gillen Aiken 2 Fr Son
(b) Address 200 Valley St.

17 (a) Burial (b) Date thereof NOV 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Ruth Wiedefeld
(b) Address 900 E Biddle St

19 NOV 4 - 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1947 at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1- 1947 to Nov 3- 1947, and that I last saw her alive on Nov 2 1947

Immediate cause of death	Duration
Acute Dilatation Heart	1 day
Due to Coronary Thrombosis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gell Hall M. D.
Address 1631 E North Av Date signed 11/4/47

VS 150

X

656595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 656595

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Bengies (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #15 Box 197 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel C. Livingstone (LIVINGSTON)

3 (b) If veteran, name war

3 (c) Social Security Account No. 416-14-1000

4. Sex W | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married.

6 (b) Name of husband or wife Maggie nee Nelson

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Oct. 21 - 1902

8. AGE: Years 45 | Months 0 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant R. N. Tyson

(b) Address 3003 Pulaski Hgh

17 (a) Removal (b) Date thereof Nov. 4-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Decatur, Alabama

18 (a) Funeral director John H. Connelly

(b) Address 1101 Eastern Ave Balto

19 (a) NOV 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Nov 1947, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1 Nov 47 at 5:30 P.M. Eastern Ave.
(b) Where did injury occur? Rt. 40 Chesaco Park Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work?
(d) Means of injury Hit by car and/or

23. Signature Earl A. Royer M.D.
Medical Examiner
Date signed 2 Nov 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 191

056596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No. 056596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1938 Ridgehill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 Ridgehill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM A. DOERING

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Annie Doering
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Saxony, Germany
(Town, county, and state)
10. Usual Occupation Cabinet Maker
11. Industry or business

FATHER
12. Name Louis Doering
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Louis A. Reuther
(b) Address 2017 Clifton Ave.

17 (a) Burial (b) Date thereof 11/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 4 - 1947 (b) Huntington Williams, M.D.
(Filed record by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 19 47 at 5:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 47 to Nov 1 19 47, and that I last saw h[illegible] alive on Oct 31 19 47.

Immediate cause of death	Duration
(a) Acute Cardiac Failure due to	1 month
(b) Acute Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry A. Shuman M.D.
Address 1911 W. Mount Royal Ave. Date signed 11/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

656597 BALTIMORE CITY HEALTH DEPARTMENT 656597

CERTIFICATE OF DEATH 1937 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Liberty Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Andrews Moffatt

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Dr. Geo. S. Moffatt
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 8, 1880

8. AGE: Years	Months	Days	If less than one day
67	4	25	hr. min.

9. Birthplace Bradford, Pa.
(Town, county, and state)
10. Usual Occupation Ward Clerk
11. Industry or business Johns Hopkins Hospital

FATHER
12. Name James Lawton Andrews
13. Birthplace Pa.

MOTHER
14. Maiden Name Rosalia Porter
15. Birthplace Pa.

16 (a) Informant Mrs. James D. C. Downes
(b) Address Liberty Rd., Randallstown

17 (a) Burial (b) Date thereof 11/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 4 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3- 1947 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl A. Royer M.D.
Medical Examiner
Date signed 11-3-47

G56598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3830 Barrington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3830 Barrington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADELAIDE M. GLOVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Russell K. Glover
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1880

8. AGE: Years	Months	Days	If less than one day
67	7	27	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Davis
13. Birthplace Virginia

MOTHER
14. Maiden Name Alice Clark
15. Birthplace Virginia

16 (a) Informant Mr. Russell K. Glover, Sr.
(b) Address 3830 Barrington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 4 1947 (b) Huntington Williamsport, Md.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1947, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947, to Nov. 2 1947, and that I last saw h.e.r. alive on Nov. 2 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertension C.V.D.	
Chronic parenchymatitis	
Due to	
Other Conditions Pernicious Anemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. N. Freeman Jr. M. D.
Address 14 E. Eager St. Date signed 11/3/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information required should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 056599

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2113 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OLLA B. SLADE

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1866

8. AGE: Years	Months	Days	If less than one day
81	7	29	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business self

FATHER
12. Name Luther Slade
13. Birthplace Md.

MOTHER
14. Maiden Name Keturah -
15. Birthplace Md.

16 (a) Informant Mrs. Evelyn Pearson
(b) Address 2113 N. Fulton Ave.

17 (a) Burial (b) Date thereof 11/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 4 - 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1947 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 2 1947 to Nov. 1 1947, and that I last saw h[illegible] alive on Nov. 31 1947.

Immediate cause of death	Duration
Arterio Sclerosis.	about
Hypertension.	years
Due to Chr. Myocarditis	
Due to Old Age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert C. Slade M. D.
Address 1 Md Arts Bldg Date signed 11-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

056600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 056600

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Rosalind Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Rosalind Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT WESLEY STEVENS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1870

8. AGE: Years	Months	Days	If less than one day
77	2	23	hr. min.

9. Birthplace Calvert Co., Md.
(Town, county, and state)
10. Usual Occupation Cigar Maker - retired
11. Industry or business

FATHER
12. Name William F. Stevens
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Mary Ellen Hardesty
15. Birthplace Calvert Co., Md.

16 (a) Informant Mr. Charles E. Wood, Jr.
(b) Address 3008 Rosalind Ave.

17 (a) Burial (b) Date thereof 11/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 4 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1947 to Nov 2 1947
and that I last saw him alive on Nov. 2 1947

	Duration
Immediate cause of death Acute Congestive Heart failure	
Due to Hypertension & arteriosclerosis	
Due to	
Other Conditions Heart block	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis R. Mazur M.D.
Address 4227 Park Heights Ave. Date signed Nov. 4 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. ANSWER ALL QUESTIONS. Use additional sheet of information should be necessary to describe fully and correctly. Cite the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

G56601 B.C.# 9.69077 BALTIMORE CITY HEALTH DEPARTMENT G56601
CERTIFICATE OF DEATH 101 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland W. B. G. H.
(b) Street address Raynor + Dukeland Ave
(c) Hospital or institution: W. B. G. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1935 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Wallis Jr.
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 3 - 1943.

8. AGE: Years	Months	Days	If less than one day
4	8	29	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles H. Wallis Sr.
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name Eileen Morris.
15. Birthplace Md.

16 (a) Informant Myrtle Elgert.
(b) Address 319 Gwynn Ave.

17 (a) Burial. (b) Date thereof Nov. 5-47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

19 (NOV 4 1947) (Huntington Williams, M.D.)
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1947 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1947, 3:00 P.M. to Nov. 2 1947, 3 P.M. and that I last saw h. i. alive on Nov. 2 1947, 5:30 P.M.

Immediate cause of death	Duration
Atelectasis bilateral, 2/ abdominal distention 2/ paralytic	
Due to adhesions	
McBurney incision rec'd	
Due to Obstruction of Intestines	
Other Conditions Cardiac dilatation surgical shock	

(Include pregnancy within 3 months of death)
Date of operation Nov. 2, 1947
Major findings of operation: Incarcerated lymphadenitis, abdominal
of autopsy: Bilateral atelectasis, cardiac

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature K. S. Gamble Hollins M. D.
Address West Balt. Gen. Hosp. Date signed Nov. 3, 1947

VS 150

C. J. Lubinski, M.D. / per. E. G. Merrill M.D.

G56602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1923

Registered No. G56602

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 Bolton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE R. CLARKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Harry B. Clarke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1879

8. AGE: Years	Months	Days	If less than one day
68	7	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Reichert
13. Birthplace Balto.

MOTHER
14. Maiden Name Ruth Anne Wells
15. Birthplace Balto.

16 (a) Informant Miss Eugenia Wilde
(b) Address 2628 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1947, at 1030 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to Nov 1 1947 and that I last saw h[er] alive on Oct 30 1947

Immediate cause of death	Duration
Cardiac decompensation	2 wks
Due to Rheumatic heart disease	10 yrs
Due to Mitral Stenosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. Edwin Muller M. D.
Address 2 W Read St Date signed Nov 4 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as completely as possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G56603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

G56603
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Mary's Seminary Roland Park
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Marys Seminary Roland Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: SISTER M. ALOYSIUS (MAGDALEN KELLER)

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1872

8. AGE: Years	Months	Days	If less than one day
75	6	23	hr. min.

9. Birthplace Covington Ky.
(Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Sister M. Charles
(b) Address St. Mary's Seminary

17 (a) Removal (b) Date thereof 11/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Anne's Cemetary
Location Melbourne Ky.

18 (a) Funeral director Charles H. Enright & Son
(b) Address 118 N. Mt. Royal Ave

19 (a) Date received by registrar NOV 4 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1947, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1947 to 11/3 1947, and that I last saw her alive on 11/3 1947.

Immediate cause of death: Coronary occlusion — Duration 5 days.
Due to: Arteriosclerosis with hypertension — 7
Due to:
Other Condition: Toxic Thyroid — 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Regina M. Alyia
Address 33 26 Frederick Ave Date signed 11/4/47 M. D.

94a

656604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

656604 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 N. Carey Sheet (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James H. Price

3 (b) If veteran, name war W. W. 2.
3 (c) Social Security Account No. —

4. Sex: Mal
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/1/1926

8. AGE: Years 21 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace St Mary's Co. Md (Town, county, and state)
10. Usual Occupation Labourer
11. Industry or business Blue Ridge Coal Co.

FATHER
12. Name Horace Price
13. Birthplace St Mary's Co. Md

MOTHER
14. Maiden Name Lola Thomas
15. Birthplace St Mary's Co. Md

16 (a) Informant Lola Price
(b) Address 1039 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/47 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Presstman

19 (a) 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 40

20. DATE OF DEATH Nov. 2, 1947, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry (Autopsy, Inspection or Inquiry) thereof and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of lungs and aorta.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/2/47 at apparent 9:25 P.M.
(b) Where did injury occur? Found: N.E. Cor. E. St. Mallow Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms
23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 11/3/47

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 181

G56605 G56605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Registered No. 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1151 Whatcoat St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1151 Whatcoat St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Alton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband~~ or wife Elsie Alton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown 1884

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name John Alton
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Finley
15. Birthplace Md.

16 (a) Informant Ora Alton
(b) Address 907 Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Jas. H. Kelson
(b) Address 1303 Presstman

19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 19 47, at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 19 47 to Nov 1 19 47 and that I last saw ~~him~~ alive on Oct 31 19 47.

Immediate cause of death Cardio Vascular Renal Disease — Duration 1 yr ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death).

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

I, Signature E. Williams Frey M. D.
Address 928 Penna Av Date signed 11/5/47

VS 150

G56606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G56606 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Harlem Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/27/1906

8. AGE: Years 41 | Months 4 mos | Days 5 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm A. Young
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Nelson
15. Birthplace Maryland

16 (a) Informant Joseph Young
(b) Address 554 Walnut St. Pottstown Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

19 (a) (Delivered by registrant) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1947 at 11 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of left tibia and fibula.

Due to Edema of lungs.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-2-47 at 2 A. M. 11/4
(b) Where did injury occur? Druid Hill Ave. 140' north of Pennsylvania Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury "Hit & Run"

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/8/47

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G56607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G56607 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 Madison Ave.
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Samuel Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 2, '79

8. AGE: Years	Months	Days	If less than one day
68	2	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Dorsey
15. Birthplace Md.

16 (a) Informant Mrs. Samuel Smith
(b) Address 2011 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

(a) NOV 4 1947 (b) Date rec'd by registrar Langston Williams, Registrar

V S 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 3 1947, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1947 to Oct 22 1947, and that I last saw her alive on Oct 22 1947.

Immediate cause of death	Duration
Cachexia - debility	
Due to Carcinoma of Liver	
Due to Carcinoma of Blood	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Wasserman M.D.
Address 1501 Eutaw Pl. Date signed Nov 3,

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Information should be accurate, complete and correct as to the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G56608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G56608

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp. 7

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 83 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Anna Wunder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/14/1864

8. AGE: Years	Months	Days	If less than one day
83	9	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Francis C. Wunder
13. Birthplace Md.

MOTHER
14. Maiden Name Elizibeth —
15. Birthplace Md.

16 (a) Informant Joseph Huff
(b) Address 15 N. Payson St.

17 (a) Burial (b) Date thereof 10-5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address 1911 East Ave. & Fayette St.

19 (a) NOV 4 1947 (b) Lexington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1947, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1947 to Nov. 2 1947 and that I last saw h.C.R. alive on Nov. 1 1947.

Immediate cause of death	Duration
Myocardial and respiratory failure,	
Due to fractured femur	
Due to senility.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul E. Manning M. D.
Address Bon Secours Hosp. Date signed 11/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Where there is no information, write "unknown." Give the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

G56609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56609

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be answered. Use "None" where necessary. Do not write the cause of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3318 Shirkland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 & 8
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3318 Shirkland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda E. Cooke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clinton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17, 1898

8. AGE: Years 49 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER
12. Name Wachenfuss
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schwartz
15. Birthplace Germany

16 (a) Informant E. Clinton Cooke
(b) Address 3318 Shirkland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 7 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location 2400 Fredrick Ave

18 (a) Funeral director John J. Cavegn & Son
(b) Address 961 Hollins St.

19 (a) NOV 4 1947 (Date rec'd by registrar) (b) Huntington Wills, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1947 at 7:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1947 to Nov. 4 1947 and that I last saw h[illegible] alive on Nov 4 1947.

Immediate cause of death: Apoplexy with Left Hemiplegia — Duration: 5 months 5 days
Due to: Hypertensive Cardio Vascular Disease
Due to:
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred Cole M. D.
Address 1934 Wilkens Ave. Date signed Nov. 4, 1947

C56610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. C56610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2728 Winchester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2728 Winchester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) J
If yes, name country

3 (a) FULL NAME Elizabeth V. McCann

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edward B.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept 13th 1867

8. AGE: Years: 80 | Months: 1 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: home work

11. Industry or business: at home

FATHER 12. Name: Robert O Elliot

13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden Name: Catherine Philpot

15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs Edward B. McCann

(b) Address: 2728 Winchester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 | 5 | 47 (month, day, year)

(c) Cemetery or crematory: Mount Catholic Cem

Location: 4300 Old Frederick Rd

18 (a) Funeral director: John F Cannon & Son

(b) Address: 901-03 Hollins St.

19 (a) NOV 4 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2nd 1947, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Nov 2 1947, and that I last saw h.. alive on Nov 1st 1947.

	Duration
Immediate cause of death: Terminal bronchopneumonia.	
Due to: Carcinoma of rectum & metastases to liver.	2 yr
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: [illegible] M.D.

Address: 642 Nash Bldg Date signed 11-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

056611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 056611

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232- N. Harrison Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29 1887

8. AGE: Years	Months	Days	If less than one day
60	6	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Out of work

11. Industry or business

FATHER
12. Name John Robinson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Estelle Broadley
15. Birthplace Baltimore Md

16 (a) Informant Hattie Robinson
(b) Address 141 W Cross St

17 (a) Burial (b) Date thereof 11/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A.B. Co. Md

18 (a) Funeral director Sarah L Brownson
(b) Address 1084 W Montgomery St

19 (a) NOV 4 - 1947 (b) Washington Hollins, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1947, at 12.30 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature per John L. Davis Medical Examiner M.D.

Date signed 11/1/47

656.12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓166

656.12 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Generel Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0.0.2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 178 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Wilkes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/30/28

8. AGE: Years 18 19 (22) | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Out of work

11. Industry or business

FATHER
12. Name James Jones
13. Birthplace N. C.

MOTHER
14. Maiden Name Lucile Lee Wilkes
15. Birthplace S. C.

16 (a) Informant Mary Wilkes
(b) Address 178 W Cross Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/47 (month) (day) (year)
(c) Cemetery or crematory Bates National Cem
Location Bates Md

18 (a) Funeral director Isaac L Brunston
(b) Address 108 W Montgomery St

NOV 4 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1947, at 7 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet wound of heart and left lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-47 at 6 49 P. M.
(b) Where did injury occur? 169 W. Cross Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NO
(d) Means of injury Firearms

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 11-1-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B.C. 63924

G56613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G56613

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Filbert Street.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME NANCY C. ISENMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1 1946

8. AGE: Years	Months	Days	If less than one day
	11	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name Chas F. Isenman
13. Birthplace Both. Pa.

MOTHER
14. Maiden Name Sara B. Rosenberger
15. Birthplace Ingersdale Pa

16 (a) Informant Mr Charles F Isenman
(b) Address 1412 Filbert St

17. (a) Burial (b) Date thereof NOV 6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Gor Ritchie Highway
18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St
NOV 4 - 1947 (b) Washington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1947, at 7.10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho-pneumonia

Due to.....

Other Conditions Anemia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Emil L Rozen M.D.
Medical Examiner
Date signed 11-4-47

VS 151

G56614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G56614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1435- N. Patterson Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EDWARD J. COLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5 - 1906

8. AGE: Years 49 | Months 2 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Richmond Cab Co.

FATHER
12. Name John B.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emma L. Armstrong
15. Birthplace Baltimore

16 (a) Informant John D. Cole
(b) Address 2306 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/47 (month) (day) (year)

(c) Cemetery or crematory Dulaney National
Location Frederick Rd.

18 (a) Funeral director Edward F. Hoffman
(b) Address 1629 Broadway

19 (a) NOV 4 - 1947 (Date rec'd by registrar) (b) Huntington Holliday M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1947, at 5.05 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11-4-47

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G56615

PLEASE WRITE PLAINLY, with unfading ink. Erase nothing. Write the causes of death clearly and legibly. Give correct age is especially important. Physicians: please write th

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 99 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 Fremont Ave
1535 W. Fremont (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Mma

3 (a) FULL NAME Joseph M. Butler

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/29/1900

8. AGE: Years 47 | Months 2 | Days 6 4 | If less than one day hr. min.

9. Birthplace Mitchell Co., Ga.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Joseph M. Butler Sr.
13. Birthplace Mitchell Georgia

MOTHER 14. Maiden Name Anna McGowen
15. Birthplace Mitchell Georgia

16 (a) Informant Joseph M. Butler
(b) Address 401 South Palmer St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore city

18 (a) Funeral director Joseph A. Sively
(b) Address 660 West Lane Street

19 (a) NOV 4 - 1947 (Date rec'd by registrar) (b) Printing for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2 1947 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1947 to 11/2 1947 and that I last saw him alive 11/2 1947

Immediate cause of death Generalized Carcinoma Tosis — Duration ?

Due to

Due to

Other Conditions Pleural Effusion Left

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinomatosis Throughout Abdominal Cavity

of autopsy: Under Consideration

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Carson

Address 1514 Division St Date signed 11/3/47

PHYSICIAN

Underline the cause to which death should be charged primarily.

X

56616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

Registered No. G56616

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st Sts.
(c) Hospital or institution:
US Marine Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W. 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Henry Besse

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1881

8. AGE: Years	Months	Days	If less than one day
66	2	17	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Besse
13. Birthplace Germany

MOTHER
14. Maiden Name Bernadine ~~Lapp~~ Koop
15. Birthplace Germany

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 11/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Pitcher & Hathaway

18 (a) Funeral director Elizabeth A. Earle Inc.
(b) Address 115 E. West St.

19 (a) NOV 4 1947 (b) Hunting Jr. Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 19 47, at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 19 47, to Nov. 3 19 47, and that I last saw h. in alive on Nov. 3 19 47.

Immediate cause of death	Duration
(1) Carcinoma of tongue with ulcerating 1st floor	9 mos.
Due to (a) mouth.	
(2) Metastatic Carcinoma	7 mos.
Due to (b) cervical lymph nodes.	
Other Conditions Cirrhosis of Liver.	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred E. Strisower M.D.
Address U.S. Marine Hosp. Date signed 11/3/47.

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

566617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 566617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Fait Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) w b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PETER J. McFAUL

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 215-07-4729

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1906.

8. AGE: Years	Months	Days	If less than one day
41	6	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Boiler Maker.
11. Industry or business Bethlehem

FATHER
12. Name John McFaul
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Donohue
15. Birthplace Baltimore, Md.

16 (a) Informant Anna McFaul (Mother)
(b) Address 3814 Fait Ave.

17 (a) Burial (b) Date thereof 11- 6- 47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location 7225 Eastern Ave.

18 (a) Funeral director Charles L. Zeiler.
(b) Address 901 S. Conkling St.

19. (a) (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1947, at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 9 1946 to Nov. 3 1947, and that I last saw h[illegible] alive on Nov. 3 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Coronary Occlusion.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward A. Flanagan Jr. M. D.
Address 3503 Fait Ave Date signed Nov 3, 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

G56618
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dd a.
(e) Length of stay in Baltimore (yrs., mos., or days) D. d. a.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 Elliott Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Orla Alley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	divorced

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Kentucky
(Town, county, and state)
10. Usual Occupation Brewery worked
11. Industry or business

FATHER
12. Name John F. Alley
13. Birthplace Kentucky

MOTHER
14. Maiden Name Lucia A. Stuntill
15. Birthplace Kentucky

16 (a) Informant Rose Schooley
(b) Address 1376 N. Fourth st.

17 (a) Burial (b) Date thereof 11 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union Cemetery
Location Columbus Ohio

18 (a) Funeral director John J Duda
(b) Address 2129 Hudson st.

19 (a) (Date rec'd by registrar) (b) Wm. F. Williams Registrar

NOV 4 - 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1947, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rogen M.D.
Medical Examiner.
Date signed 2 Nov 47

G56619 BALTIMORE CITY HEALTH DEPARTMENT G56619

CERTIFICATE OF DEATH

Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olevie G. Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years	Months	Days	If less than one day
27			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) REMOVAL (b) Date thereof NOV. 4, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory RONCEVERTE
Location RONCEVERTE, W. VA.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

NOV 4 1947 (a) (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1947, at 12 Noon M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Fox M.D.
Medical Examiner
Date signed

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G56620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 56620 (Registered No.)

51 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3101½ Willoughby Rd
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Walter S Marks

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sarah I. Marks

6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) July 20, 1863

8. AGE: Years 84 | Months 3 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Hannah Moore Academy

FATHER
12. Name Thomas Marks
13. Birthplace England

MOTHER
14. Maiden Name Mary Jane Clarke
15. Birthplace England

16 (a) Informant Mrs. Irene Burgan
(b) Address 1301½ Willoughby Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Nov 7 1947 (Date received by registrar) (b) ..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/47 19..., at 5.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/45 1947 to 11/3 1947 and that I last saw h.m alive on 11/2 1947

Immediate cause of death Coronary Thrombosis — Duration .....

Due to Coronary heart disease — .....

Due to ..... — .....

Other Conditions Anemia of years — .....

(Include pregnancy within 3 months of death)

Date of operation 9/16/47

Major findings of operation: Carcinoma of prostate

of autopsy: Coronary Heart disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature L. H. Tenbrink M. D.
Address Sinai Hospital Date signed 11/3/47

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, with ordinary pen and ink. Be sure to give the causes of death clearly and legibly. Physicians: please write the correct age. Item 8 is especially important.

G56621 BALTIMORE CITY HEALTH DEPARTMENT ✓ G56621
Registered No.

TM. 113427

CERTIFICATE OF DEATH 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 Hollins St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME
Florence Stinefelt

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Bernard A. Stinefelt
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 18th 1865

8. AGE: Years 82 | Months 6 | Days 17 16 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Deceased Joseph Benson
13. Birthplace North Carolina

MOTHER
14. Maiden Name Deceased Harriet Lee
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 11-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director George L. Ephraim
(b) Address 2101 Pulaski Ave.

19 (a) ____ (Date rec'd by registrar) Huntington Williams, M.D.
NOV 8 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov/4th.1947 19____, at 12.15 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29th 19 47 to Nov. 4th 19 47 and that I last saw h.er alive on Nov. 4th 19 47.

Immediate cause of death: Broncho Pneumonia — Duration: 2 wks
Due to: Senility + Debility — 4 yrs
Due to: ____
Other Conditions: Fracture left femur; Fracture left humerus — 10 wks
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence August 29 1947 7 P.M.
(c) Where did injury occur? Maya Flats A.A.C.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Resort While at work? No
(Specify type of place)
(e) Means of injury: Fell down one step.

23. Signature: H. E. Frost M.D.
Address 4940 Eastern Ave Date signed 11-4-47

Howard J. Mergia, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B.C. # 91496 Dead

656622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

656622 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave & Dukeland Sts
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County over
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 S. Fulton Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard B. Richardson.

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1947

8. AGE: Years —; Months —; Days 28; If less than one day ___ hr. ___ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Bernard B. Richardson
13. Birthplace Maryland.

MOTHER
14. Maiden Name Edna E. Nash
15. Birthplace Maryland

16 (a) Informant Bernard B. Richardson
(b) Address 104 S. Fulton Ave.

17 (a) Burial (b) Date thereof 11-5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland.

18 (a) Funeral director George L. Howat
(b) Address 210 N. Frederick Ave.

19 (a) ___ (b) ___
(Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION Nurse 4

20. DATE OF DEATH October 1947, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1947 to Oct 4 1947 and that I last saw h[illegible] alive on: Oct 4 1947

Immediate cause of death: Cardio-respiratory arrest. — Duration
Due to Internal intracranial pressure. —
Due to Hydrocephalus internal —
Other Conditions Marasmus —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Tucker M. D.
Address 1 West Baltimore Date signed 11/4/47

PLEASE WRITE PLAINLY, with ordinary ink. Physicians: please write the cause of death clearly and legibly. Be sure the age is correct as it is especially important.

Awaiting for Histology

Heil Hosp

556623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 556623

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 739 Grantley St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 739 Grantley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Flora C. Hesser

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Andrew
6 (c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) April 22, 1861

8. AGE: Years 86 yrs. Months 6 Days 13 If less than one day hr. min.

9. Birthplace Buckhannon W. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Colerider
13. Birthplace West. Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Lester Nally
(b) Address 739 Grantley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/47 (month) (day) (year)
(c) Cemetery or crematory Blue Mount
Location Grafton W. Va.

18 (a) Funeral director Frank L. Neuvee
(b) Address Pikesville, Md

19 (a) Nov 5 1947 (Date received by local registrar) (b) Huntington Williamsport, Md

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1947, at 11.9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1946, to Nov 4 1947, and that I last saw him alive on Oct 31 1947.

Immediate cause of death	Duration
Myocardial insufficiency	5 Days
General Carcinomatosis	1 Year
Due to: Carcinoma of the Right Breast	3 Yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: W. M. Barnard Hood M. D.
Address 2200 Garrison Blvd Date signed 11/4/47

56624

BALTIMORE CITY HEALTH DEPARTMENT ✓ G56624

CERTIFICATE OF DEATH 124B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Genl Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 Tyndale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUTH C. KRAUSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband William F. Krause
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4th 1889

8. AGE: Years	Months	Days	If less than one day
57	11	0	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Richard W. Hastings
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Connellee
15. Birthplace Md.

16 (a) Informant William F. Krause
(b) Address 3219 Tyndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 NOV 5- 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1947, at 9:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1947 to 11/4 1947 and that I last saw her alive on 11/4 1947.

Immediate cause of death Hypostatic Pneumonia, Pulmonary Edema

Due to Subarachnoid Hemorrhage

Due to Cirrhosis of Liver

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Cirrhosis of Liver

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Grubenstahy M.D.
Address West Baltimore General Hospital Date signed 11/7/47

VS 150

X

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the cause of death clearly and legibly. Be sure that the correct age is especially important.

G56625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2547 N. Howard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2547 N. Howard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Frances Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Morris P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1883

8. AGE: Years 64 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Hall
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Mary Jane Jackson
15. Birthplace Calvert Co. Md.

16 (a) Informant Morris P. Hall
(b) Address 2547 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Chas. H. Hudson
(b) Address 1631 Druid Hill Ave.

NOV 5 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1947 at 11 45 A. M.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 28 1947 to Oct. 31 1947 and that I last saw h[illegible] alive on Oct 31 1947.

Immediate cause of death: Cerebral Hemmorrhage — Duration: 10 da.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
(f) Signature Knox A Johnson M. D.
Address 2329 Guilford Ave Date signed Nov 5 1947

Please write plainly with pen and ink. Give cause of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

56626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 56626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 N. Luzerne Avenue
(c) Hospital or institution:

6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA M. HAUSER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Frank Hauser
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) April 24, 1881

8. AGE: Years	Months	Days	If less than one day
66	6	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Rejzek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Catherine Hoerner
15. Birthplace Baltimore, Md.

16 (a) Informant Arthur F. Hauser - son
(b) Address 3425 Shannon Drive

17 (a) Burial (b) Date thereof 11/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 NOV 5 - 1947 Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1947 at 8 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947, to Nov 1 1947, and that I last saw her alive on Nov 1 1947

Immediate cause of death: coronary thrombosis · cardio-vascular-Renal — Duration 11/1/47
Due to arteriosclerosis
Due to natural by perforation
Due to
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Louis H. Krumrein M. D.
Address 222 No. Luzerne Date signed 11/7/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G56627

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3429 Mayfield Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3429 Mayfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY HESTER THOMAS

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: William R. Thomas
6 (c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) April 19, 1896
8. AGE: Years 51 | Months 6 | Days 14 | If less than one day: hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James G. Roberts
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Hester Lee Long
15. Birthplace Baltimore, Maryland

16 (a) Informant William R. Thomas
(b) Address 3429 Mayfield Avenue -13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) NOV 5 - 1947 (Date rec'd by registrar) (b) Huntington Wills Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH November 2 1947 at 12.08

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Nov. 2 1947
and that I last saw h alive on 19

Immediate cause of death	Duration
Acute Heart Failure	
Due to Metastatic Adeno Carcinoma of Breast	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H B Stevens M.D.
Address 3400 Eastern Ave Date signed 11/7/47

VS 150

G56628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G56628

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5219 Putney Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5219 Putney Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISA JURGENS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1862

8. AGE: Years 85 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John P. Koch
13. Birthplace Germany

MOTHER
14. Maiden Name Eva K. Koch
15. Birthplace Germany

16 (a) Informant Mr. Howard Jurgens
(b) Address 5219 Putney Way - 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/47 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) [illegible] (b) [illegible] Registrar

VS 190

MEDICAL CERTIFICATION P

20. DATE OF DEATH Nov. 2 1947, at 11.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947, to Nov. 2 1947, and that I last saw h[illegible] alive on Nov 2 1947.

Immediate cause of death	Duration
Coronary occlusion	20 min.
Due to Generalized arteriosclerosis	15 yrs.
Due to Senility	15 yrs.
Other Conditions Bronchopneumonia, presumably Influenza, bilateral	1 week

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. S. Chatham M. D.
Address 6 E 10 St. Date signed Nov 4 47

56629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

Registered No. 656629

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6200 BIRCHWOOD AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6200 BIRCHWOOD AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE. F. DEDERER.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER.

6 (b) Name of husband or wife ELIZ. LOUISE DEDERER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 16 1872

8. AGE: Years	Months	Days	If less than one day
75	5	19	hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation INTERNAL REVENUE DEPUTY

11. Industry or business

FATHER
12. Name CHRISTOF DEDERER
13. Birthplace GERMANY.

MOTHER
14. Maiden Name NOT KNOWN
15 Birthplace NOT KNOWN

16 (a) Informant MRS FREDA. K KNABE
(b) Address 6200 BIRCHWOOD AVE

17 (a) BURIAL (b) Date thereof 11-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST PAULS CEM
Location DRUID HILL PARK

18 (a) Funeral director MRS Chas A E RODE
(b) Address 2327 EDMONDSON AVE

19 NOV 5 1947 Huntington Williams M.D.
(Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1947, at 12 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Nov 4 1947, and that I last saw him alive on Nov 3 1947.

Immediate cause of death: Cardiac Syncope — Duration about [illegible] Yrs

Due to: Virus Pneumonia

Due to:

Other Conditions:

(Includes pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. Latrobe Ewalt M. D.

Address 2945 St Paul St Date signed 11/5/47

G. LATROBE EWALT, MD

V S 190

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G56630

AMMON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 N. Roe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 N. Roe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosina Ammon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles J. Ammon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 - 1878

8. AGE: Years	Months	Days	If less than one day
69	5	27	hr. min.

9. Birthplace Germany (Town, County, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Schiffler
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Frederick W. Ammon
(b) Address 529 N. Roe St.

17 (a) Burial (b) Date thereof Nov. 6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bal Lawn Mem. Park
Location Eastern Ave.

18 (a) Funeral director John J. Miller
(b) Address 2334 Jefferson St.

19 NOV 5 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1947, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1947 to Nov. 3 1947, and that I last saw h.. alive on Nov. 3 1947.

Immediate cause of death	Duration
myocardial insufficiency	36 hrs.
Due to myocarditis	?
Due to	
Other Conditions arterio, hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. C. Tobitsch
Address 447 N. Kenwood Ave. Date signed 11/4/47 D

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

656631 ✓ Registered No. 656631

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N Wolfe
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Lee Forrester ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Married

6 (b) Name of husband or wife Susie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1900

8. AGE: Years	Months	Days	If less than one day
46	10	10	hr. min.

9. Birthplace Nottaway County Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bubbler Shell Co.

FATHER
12. Name Richard Forrester
13. Birthplace Nottaway Co. Va.

MOTHER
14. Maiden Name Susan Fitzgerald
15. Birthplace Nottaway Co. Va.

16 (a) Informant Susie Forrester
(b) Address 822 N. Wolfe St

17 (a) Removal (b) Date thereof Nov. 6/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Creuse Va

18 (a) Funeral director Mrs Robt G Elliott Dft
(b) Address 1129 N. Caroline St

19 (a) Nov 5 - 1947 (b) Kenneth for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1947, at 11:0 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27 1947, to Nov. 4 1947, and that I last saw h[illegible] alive on Nov. 3 1947.

Immediate cause of death	Duration
Pneumonia,	1 wk
Due to Upper Respiratory Infection	3 wks
Due to	over
Other Conditions Hypertension, mild	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel
Address 507 N. Caroline St. 5 Date signed 11-4-47 M. D.

VS 150

R. W. McDaniel ✕

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

056632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 056632

Physicians: please write the causes of death clearly and legibly. Information as to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Tumbridge Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Emmett Hooke

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Mar.

6 (b) Name of husband or wife Gertrude Tierney
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) May 13, 1886

8. AGE: Years	Months	Days	If less than one day
61	5	23	21 hr. min.

9. Birthplace New York, N.Y.
(Town, county, and state)
10. Usual Occupation Plaster
11. Industry or business

FATHER
12. Name Michael Hooke
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Jennie Mc Clenahan
15. Birthplace Balto, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 11-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Old Frederick Rd.

18 (a) Funeral director John A. Moran
(b) Address 3600 E. Balt. St. (Ex)

19 (a) NOV 5 - 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 19 47, at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 19 47 to Nov. 5 19 47, and that I last saw him alive on Nov. 5 19 47

Immediate cause of death lymphosarcoma. — Duration 10 Mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred B. Stone M.D.
Address U.S. Marine Hosp. Date signed 11/3/47.

V S 150

G56633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106B

G56633 Registered No.

write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1306 N. Rose St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 N. Rose St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Moylan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Annie M Hylan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/11/1870

8. AGE: Years	Months	Days	If less than one day
77	2	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Moylan
13. Birthplace Ire

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant James E. Mylan
(b) Address 2711 E. Biddle St

17 (a) Burial (b) Date thereof 11-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director John A. Moran
(b) Address 3600 E. Balt St.

19 (a) NOV 5 - 1947 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Nov 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Nov 1946 to 31 Oct 1947, and that I last saw h. alive on 31 Oct 1947.

Immediate cause of death	Duration
Myocardial failure	
Due to Arteriosclerosis	3 yrs
Due to Stroke	
Other Conditions Chronic bronchitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address 1513 N. [illegible] Date signed 3 Nov 47

V S 190

97

G56634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 B

G56634 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W.Fayette Street
(c) Hospital or institution:
Bon Secour Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Benson, Harford Co. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Dennis J Smith (Dennis J. Smith)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8th. 1883

8. AGE: Years	Months	Days	If less than one day
63	10	26	######## min.

9. Birthplace Harford County, Maryland
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Dairy Farm

FATHER
12. Name James T. Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Bradley
15. Birthplace Ireland

16 (a) Informant George L. Smith
(b) Address Benson, Maryland

17 (a) Burial (b) Date thereof 11/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns, Long Green
Location Baltimore Co., Maryland

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 NOV 5 - 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

V5 280

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1947 at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947 to Nov 4 1947, and that I last saw h[illegible] alive on Nov 4 1947

Immediate cause of death Respiratory failure — Duration

Due to Multiple metastasis from Ca of prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Confirmatory Catal

Major findings of operation: 7-12-47 transurethral April 1946

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William F. Barr M. D.
Address Bon Secours Hosp. Date signed 11-4-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

Registered No. 0566635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 S. Carrollton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 S. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Zwanzger

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Amelia C. Gaebel
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1877

8. AGE: Years	Months	Days	If less than one day
69	10	29	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Retired

FATHER
12. Name John H. Zwanzger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Fredericka Brunning
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Lydia Riley
(b) Address 1201 W. Lombard St.

17 (a) Burial (b) Date thereof Nov. 6, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Fred Lee Cole
(b) Address 1700 W. Fayette St

19 (a) NOV 5 - 1947 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1947 at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1947 to 11-3-47 19..., and that I last saw him alive on Nov 1 1947.

Immediate cause of death	Duration
Metastatic Carcinoma	6 years
Due to carcinoma of prostate	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Racusin M. D.
Address 206 S. Gilmor St Date signed 11.5.47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

X

56636 B.C.# D.89211 BALTIMORE CITY HEALTH DEPARTMENT ✓ G56636

CERTIFICATE OF DEATH 1947

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2648 Dulaney Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol [illegible]EA JEAN PAUL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1947

8. AGE: Years	Months	Days	If less than one day
	1	21	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Edward A. Paul
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Gertrude A. Allenbaugh
15. Birthplace Balto. Md.

16 (a) Informant Edward A. Paul
(b) Address 2648 Dulaney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. Balto Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) NOV 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1947, at 3.25 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Aspiration of vomitus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 20/5

(a) Date of injury 11-4-47 at 2 p. M.
(b) Where did injury occur? 2648 Dulaney St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Aspiration of vomitus

23. Signature Carl L Pryor M.D.
(Medical Examiner)
Date signed 11- 5-47

VS 151

G56637 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G56637

CERTIFICATE OF DEATH 97

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edgewood Nursing Home
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) About 74 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4418 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? ---- (Yes or No)
If yes, name country ----

3 (a) FULL NAME: Marie L. McFee

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ---

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---

8. AGE: Years: About 74 | Months: --- | Days: --- | If less than one day: -- hr. --- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: ---

FATHER
12. Name: Henry B. McFee
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mary C. Wall
15. Birthplace: Baltimore, Maryland

16 (a) Informant: J. Nunan McFee
(b) Address: 103 Thicket Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Meares and Son
(b) Address: 805 N. Calvert Street

19 (a) ---- (Date rec'd by registrar) (b) ---- Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 3rd 1947, at 10:30 M

21. I certify that death occurred on the date above-stated; that I attended deceased from Aug 1947 to Nov 1947 and that I last saw h. alive on Nov 3 1947.

Immediate cause of death: Arteriosclerosis, Generalized — Duration: ----
Due to: ----
Due to: ----
Other Conditions: ----
(Include pregnancy within 3 months of death)
Date of operation: ----
Major findings of operations: ----
of autopsy: ----

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ----
(b) Date of occurrence: ---- at ---- M
(c) Where did injury occur? ---- (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ---- (Specify type of place) While at work?
(e) Means of injury: ----

23. Signature: William J. Holbrook
Address: 5006 Roland Ave. Date signed: Nov 4, 1947

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Duplicate

G56638 BALTIMORE CITY HEALTH DEPARTMENT G56638

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 Webster St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Webster St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Durkan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Etta V. Hammond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/30/1881

8. AGE: Years 66 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired B & O.

11. Industry or business Engineer

FATHER
12. Name James D. Durkan
13. Birthplace Unknown

MOTHER
14. Maiden Name Ida Ogle
15. Birthplace Penn.

16 (a) Informant Mr. Frank Durkan
(b) Address 1403 Webster St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Rd. Frederick Rd.

18 (a) Funeral director J. Baker Evans
(b) Address 318 Light St.

19 (a) 11/5-1947 (Date rec'd by registrar) (b) Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1947, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1947 to Nov 3 1947, and that I last saw h alive on Nov 3 1947.

Immediate cause of death: Uremia Duodenal Diverticulum — Duration

Due to —

Due to

Other Conditions Carcinoma Sclerosis Uremia - Bronchial Asthma

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G. Scheurich

Address 1337 S. Clinton St. Date signed 11/3/47

Scheurich X

corrected page is especially important. Physicians: please write the causes of death clearly and legibly.

G56639 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G56639

CERTIFICATE OF DEATH

186a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 35 days
(e) Length of stay in Baltimore (yrs., mos., or days): 35 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Montgomery
(c) City or town: Silver Springs (If outside city or town limits, write RURAL and give town)
(d) Street No.: 8712 Reading Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Nina Eunice Ovenden

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Wid.

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 28, 1861

8. AGE: Years: 85 | Months: 11 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Bergen, NY (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: William Cook
13. Birthplace: N. Y.

MOTHER
14. Maiden Name: Mary Churchhill
15. Birthplace: N.Y.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof: 11/6/47 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) [illegible] (b) [illegible]
(Signature of registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 19 47, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 19 47 to Nov. 4 19 47 and that I last saw her alive on Nov. 4 19 47.

Immediate cause of death: Fracture left femur, subcapital with non-union — Duration: 54 days

Due to: Other conditions: Arterio-sclerotic cardio-vascular disease with calcific aortic & mitral stenosis

(2) Acute tracheo-bronchitis (Include pregnancy within 3 months of death)

Date of operation: (3) Broncho-

Major findings of operation: pneumonia left lower lobe (few days duration)

of autopsy:

UNKNOWN

FOR USE OF PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: 9-13-47 at 7 P M
(c) Where did injury occur? Nursing Home, Wash. D.C. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Nursing Home While at work? No (Specify type of place)
(e) Means of injury: Slipped & Fell to Floor

23. Signature: [signature] M. D.
P. F. van Aekeren, Medical Director
Address: Medical Officer in Charge — Signed 11/4/47

John R. Davis MD / G. A. Merrill MD

G56640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56640 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 937 Shields Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937- Shields Place.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRED DABNEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1895

8. AGE: Years	Months	Days	If less than one day
52	5	10	hr. min.

9. Birthplace Baltimore, Md.,
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Fred Dabney.
13. Birthplace Baltimore, Md.,

MOTHER
14. Maiden Name Rosa ?
15. Birthplace Md.,

16 (a) Informant Bessie Dabney
(b) Address 937 Shields Place

17 (a) Burial (b) Date thereof Nov. 7 1947.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs. Katy R. Williams
(b) Address 322 N Schroeder St

NOV 5 - 1947 (b)
(Date rec'd by registrar)

Thurlington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1947, at 8.50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed 11-4-47

X

G56641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56641

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Bank St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eddie Dunton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Q	

6 (b) Name of husband or wife Samuel Dunton.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16, 1895

8. AGE: Years	Months	Days	If less than one day
52	2	17	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Domestic.
11. Industry or business

FATHER
12. Name Harry Tyler.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Laura Snell
15. Birthplace Baltimore, Md.

16 (a) Informant Lana Riddick
(b) Address 1406 Bon Court.

17 (a) Burial (b) Date thereof Nov. 6, 1947.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

NOV 5 - 1947
(Date rec'd by registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2 1947, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature C. P. Pelunick M.D.
Medical Examiner.
Date signed 11/3/47

G56642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1284

G56642 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 N. Arlington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Glover

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Millie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-26-00

8. AGE: Years 47 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Fla. (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER 12. Name Alonzo Glover
13. Birthplace Fla.

MOTHER 14. Maiden Name Cherry Campbell
15. Birthplace Fla.

16 (a) Informant Ricardo.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 7 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williamson
(b) Address 322 N. Schroeder St

19 (a) (Date received by registrar) (b) Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1947, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1947 to Nov. 3 1947 and that I last saw him alive on Nov. 3 1947.

Immediate cause of death	Duration
Shock, vascular	24 hrs
Due to Acute pancreatis	1 wk
Due to Pancreatic lithiasis	unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 3 Nov 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √94a

G56643 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Bernardine's
(c) Hospital or institution: Church

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3217 Westwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome (Jerry) A. Thalheimer

3 (b) If veteran, name war W.W. 2

3 (c) Social Security Account No. 212-09-7844

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1903

8. AGE: Years	Months	Days	If less than one day
44	7	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name Joseph A. Thalheimer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ida Clegg
15. Birthplace Md.

16 (a) Informant Mrs. Mary E. Doty
(b) Address 3217 Westwood Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. Northern Ave.

19 (a) NOV 5 - 1947 (Date rec'd by registrar) (b) Huntington Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1947, at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed 11-4-47

X

G56644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V.132

G56644 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1142 E Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1142 E. Lombard st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas White.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Georgia White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1906

8. AGE: Years 41 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas White
13. Birthplace Va

MOTHER
14. Maiden Name Maley Turner
15. Birthplace Va

16 (a) Informant Mary Banks
(b) Address 1142 E. Lombard st

17 (a) Burial (b) Date thereof 11/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Brooklyn, Md.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brunt Lyn ave

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 5 1947

Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1947, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Nov 3 1947 and that I last saw HIM alive on Nov 2 1947

Immediate cause of death	Duration
Respiratory Failure.	
Due to Pulmonary Tuberculosis	Over 1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Bussell M.D.
Address 121 Bisquith St. Date signed 11-4-47 M. D.

X

corrected. Physicians: please write the causes of death clearly and legibly. ... age is especially important.

G56645 BALTIMORE CITY HEALTH DEPARTMENT G56645
Registered No.

CERTIFICATE OF DEATH 166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) appx 1 day
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Cherry Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Giles Road (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph B. Milburn

3 (b) If veteran, name war

(c) Social Security Account No. 220-67-1595

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10- 1909

8. AGE: Years	Months	Days	If less than one day
38	4	21	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Baugh Chemical

FATHER
12. Name Samuel Hoeum
13. Birthplace Maryland

MOTHER
14. Maiden Name Elsie Heisey
15. Birthplace Maryland

16 (a) Informant Cora Milburn
(b) Address 2704 Giles Rd - Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Nat
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomfield Ave Pimlico for Williams, Md

19 (a) 1947 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION 15

20. DATE OF DEATH November 1, 1947 at 6 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound left thigh - severed
Due to left femoral artery

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-1-47 at Between 3 & 4 A.M.
(b) Where did injury occur? 2704 Giles Road Cherry Hill Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Samuel H. Ruge M.D.
(Medical Examiner)
Date signed 11-1-47

VS 181

G56648 — Wolfertheum — G56648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 N. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 N. Collington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Volkerthum
3 (b) If veteran, name war
3 (c) Social Security Account No. 219-01-6481

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Lillian
6 (c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) Nov. 18 1891
8. AGE: Years 55 | Months 11 | Days 15 | If less than one day ... hr. ... min.
9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business City of Balto.

FATHER
12. Name Charles Volkerthum
13. Birthplace Germany

MOTHER
14. Maiden Name Henretta Dietrich
15. Birthplace Germany

16 (a) Informant Lillian Volkerthum
(b) Address 516 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.
18 (a) Funeral director M. W. E. Dyer & Sons
(b) Address Lombard & Ann Sts.
19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1947, at 3:10 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Nov. 3 1947 and that I last saw her alive on Nov. 1 1947.

Immediate cause of death	Duration
arterial Hypertension	1 yr. ?
Chronic Nephritis	? —
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Geo. A. Pattison M. D.
Address 432 E. Pattersonand Ave. Date signed 11/19/47

V S 150

X

G56647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56647

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1231 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write COUNTY, and name town)
(d) Street No. 1231 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Cannady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Grace Cannady

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 14-1894

8. AGE: Years 53 | Months 6 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace N C (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Mayo Cannady

13. Birthplace N C

MOTHER 14. Maiden Name Emma ...

15. Birthplace N C

16 (a) Informant Grace Cannady

(b) Address 1231 Harford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto Co

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

NOV 5-1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4th 1947, at 1:50 A M

21. I certify that I took charge of the remains described above, held an Inq & Aut thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....

(d) Means of injury

23. Signature William G Hatfield M.D. Medical Examiner.

Date signed Nov 4th 1947

Correct age is especially important. Physicians, please write plainly.

VS 151

G56648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G56648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3806 Hillsdale Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Hillsdale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Charlton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ruth M. Charlton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12 1901

8. AGE: Years	Months	Days	If less than one day
46		23	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Service Mgr.
11. Industry or business Chesapeake Auto Co

FATHER
12. Name Henry C. Charlton
13. Birthplace Norway

MOTHER
14. Maiden Name Matilda M. Lohmuller
15. Birthplace Baltimore Md

16 (a) Informant Ruth M. Charlton
(b) Address 3806 Hillsdale Road

17 (a) Burial (b) Date thereof Nov 7 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Harry J. Almacock
(b) Address 4204 Ridgewood Ave

19 (a) (b)
(Signature of registrar)

5 Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29, 1947, to Nov. 4, 1947, and that I last saw h.. alive on Nov. 4, 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions Chr. Endocarditis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. E. Hannon M.D.
Address 524 Medical Arts Bldg Date signed 11/7/47

M. D.

X

AB- 114811 G56649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G56649 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3519 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Schlee

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 11- 1887

8. AGE: Years 60 | Months 2 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Appel (D
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Schaub (D
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Rd.

18 (a) Funeral director Tilley & Zeigler Inc
(b) Address 403 S. Wolfe St.

19 (a) NOV 1947 Date rec'd by registrar Huntington Hollidaysburg, Md. Registrar

V S 150

MEDICAL CERTIFICATION PH

20. DATE OF DEATH November 4- 19 47 at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 19 47 to 11-4 19 47 and that I last saw h 9F alive on 11-4 19 47

Immediate cause of death: Bronchopneumonia — Duration: 2 weeks

Due to: Paget's Disease, Hypertensive Cardio-Vascular Disease — Duration: 10-15 yrs; 4-5 yrs?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 11-4-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56650 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Bank St.
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 3814 Bank St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME WILLIAM ARKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Anna Arkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-1870

8. AGE: Years	Months	Days	If less than one day
77	10	3	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant John W. Zang
(b) Address 3814 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-47 (month) (day) (year)
(c) Cemetery or crematory Oak Spring
Location Eastern Ave Ext

18 (a) Funeral director Lilly & Zeigler Inc
(b) Address 403 S. Wolfe St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

NOV 5 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1947, at 3:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 to 10; and that I last saw him alive on 10

Immediate cause of death: Arteriosclerotic cardiovascular disease — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Merrill Asst. Medical Examiner M.D.

Address 700 E. Lee St. Date signed 11/4/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G56651

CM. 16091

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 E. Chase ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George C. Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W idowed

6 (b) Name of husband or wife

6 (c) If alive, give age 4th years

7. Birth date of deceased (mo., day, yr.) Sept. ~~18 1882~~ 1888

8. AGE: Years 59 | Months 2 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William A. Schmidt
13. Birthplace MD.

MOTHER
14. Maiden Name Elizabeth Sann
15 Birthplace Germany

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Eastern Ave

18 (a) Funeral director John C. Mullen Inc.
(b) Address 2435 E. Oliver St

19 (a) Nov 5 1947 (Date received by registrar) (b) Thurlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4- 1947, 10.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19-1930 to Nov. 4- 1947, and that I last saw him alive on Nov. 4- 1947.

Immediate cause of death: Probable Myocardial infarction Acute

Due to Arteriosclerotic Heart Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Immediate
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 11-4-47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

Dr. Peake G56652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G56652 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2815 White Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 White Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hush, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Fannie E. Hush

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1859

8. AGE: Years 88 | Months 0 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. John Presser
(b) Address 2815 White Avenue, 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

NOV 6 1947 (Date rec'd by registrar) Clarington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1944 to 11-5 1947 and that I last saw him alive on 11-3 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	6 days
Due to Arterial Hypertension	3-5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Peake M. D.
Address 4105 Harford Rd Date signed 11-5-47

VS 150

G56653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56653 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 E. 31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise G. WAGNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	M

6 (b) Name of husband or wife Harry F. Wagner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12-1885

8. AGE: Years	Months	Days	If less than one day
62	1	23	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Herman Keller
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina
15. Birthplace Germany

16 (a) Informant Mr. Harry F. Wagner
(b) Address 2027 E. 31st Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Md.

18 (a) Funeral director Leonard J. Luckman Sanford Lord
(b) Address 5305

19 (a) [illegible] (State local registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1947, at 5:45 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Myocardial degeneration.
Edema of lungs.

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 11/3/47

VS 191

G56654

HEALTH DEPARTMENT—CITY OF BALTIMORE

G56654

CERTIFICATE OF DEATH

✓ 100 C

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3010 Iona Ter. St., 4 Ward)

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 49 yrs. 10 mos. 9 ds. How long in U. S. If of foreign birth?.....yrs.....mos.....ds.

2. FULL NAME Clinton E. Heinz

If U.S. Veteran specify WAR No

(a) Residence: No. 3010 Iona Ter. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

3a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Grace M. Heinz

6. DATE OF BIRTH (month, day, year) Dec 26 1897

7. AGE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
49	10	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Dispatcher

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. B & O R R

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME Andrew J. Heinz

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Elizabeth Uhlenberg

16. BIRTHPLACE (city or town) (State or country) Balto Md

17. INFORMANT Grace Mayes

(Address) 3010 Iona Terr

18. BURIAL, CREMATION, OR REMOVAL

Place Lorraine Pk Date Nov 8, 1943

19. UNDERTAKER A. Howard Evans

(Address) [illegible]

20. FILED NOV 5 1943, 19.....

Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 11/5, 1943

22. I HEREBY CERTIFY, That I attended deceased from 11/5/43, 19.... to 11/5/43, 19....

I last saw h... alive on....., 19.... Death is said to have occurred on the date stated above, at 6:45 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Thrombophlebitis, Lower extremities	1943
Pyrexia Vague	1943
Pulmonary Embolism	11/5/43

Other contributory causes of importance:

Was an operation performed? No Date of.....

For what disease or injury?.....

What test confirmed diagnosis? — Was there an autopsy?.....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify.....

(Signed) Walter E. Farlow M. D.

(Address) 1331 Halford Rd.

X

056655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 056655

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Hall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RABBI JACOB David GORDON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Cherne.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Rabbi
11. Industry or business

FATHER 12. Name Judith Gordon
13. Birthplace Russia

MOTHER 14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Mrs. Eva Rubin
(b) Address 1627 East 53th St Brooklyn N.Y.

17 (a) (Burial, cremation, or removal) (b) Date thereof Nov. (month) (day) (year)
(c) Cemetery or crematory Union Field Cemetery
Location Long Island N.Y.

18 (a) Funeral director Levinson & Bros.
(b) Address 1126 W. North ave

NOV 6 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1947, at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1947, to 11/5 1947, and that I last saw h[illegible] alive on 11/5 1947.

Immediate cause of death	Duration
Uremic Convulsion	
d heart failure	
Due to Arteriolar Nephrosclerosis	
& Prostatic Hypertrophy & Uremia	
Due to Hypertensive Arterio-	
sclerotic C.V. Disease	
Other Conditions Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Sussman
Address Sinai Hospital Date signed 11/5/47 M.D.

VS 150

56656 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 656656

CERTIFICATE OF DEATH 137a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2M
(e) Length of stay in Baltimore (yrs., mos., or days) 78 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) ~~City or~~ town Rogers Forge (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Dunkirk Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adolph Schmidt

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Christina –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1869

8. AGE: Years	Months	Days	If less than one day
78	2	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Veronica – ? –
15. Birthplace Germany

16 (a) Informant Chas. J. Mahan Son
(b) Address 322 Dunkirk Rd Balto

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/8/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address NOV 6 1947 7 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 1947, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1947 to 11/5 1947, and that I last saw him alive on 11/4 1947.

Immediate cause of death Respiratory failure
Due to Cardiac failure
Due to Senility
Other Conditions Prostatectomy - for Benign Prostatic Hypertrophy + Cystic Calculus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: B.P.H. Cystic Calculus (Uric Acid)
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature X. A. Mitchell
Address Md. Gen. Hosp. Date signed Nov 7 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

56657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 150

Registered No. 56657

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3632 Hineline Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 d
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3632 Hineline Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl D. Wolf

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Anton J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1892

8. AGE: Years	Months	Days	If less than one day
55	8	6	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Louis P. Lohr
13. Birthplace Virginia

MOTHER
14. Maiden Name —
15. Birthplace Virginia

16 (a) Informant Mr. Anton J. Wolf
(b) Address 3632 Hineline Ave.

17 (a) Burial (b) Date thereof 11. 8. 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 (a) NOV 6 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by the Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 1947 at 2:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to Nov 5 1947 and that I last saw her alive on Nov 4 1947

Immediate cause of death Metastatic Carcinoma — Duration uncertain

Due to carcinoma left breast — uncertain

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Rocoem M.D.
Address 206 S. Gilmor St. Date signed 11.5.47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

556658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 556658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2221 Wilkens Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2221 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Spittel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Anna M. Spittel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1873.

8. AGE: Years 74 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired Capt.

11. Industry or business Balto. City Fire Dept.

FATHER
12. Name Rhinehart Spittel
13. Birthplace Unknown

MOTHER
14. Maiden Name Margaret Schwalm
15. Birthplace Unknown

16 (a) Informant Mrs. Margaret Polo, daughter
(b) Address 109 S. Wickham Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 7/47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Spittel
(b) Address 4101 Edmondson Ave.

NOV 6 - 1947
(a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4/47. 19 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Nov 4 1947 and that I last saw h[illegible] alive on 11/4 1947

Immediate cause of death Arterio-sclerotic cardio vascular disease — Duration 1 yr

Due to — Duration

Due to — Duration

Other Conditions Cerebral thrombosis — Duration 1 wk

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 2070 Wilkens Ave Date signed 11/7/47

G56659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 83a

Registered No. G56659

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5605 Wayne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3911 Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annabelle Emerick

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Widow

6 (b) Name of husband or wife William Sevins
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 20-1867

8. AGE: Years	Months	Days	If less than one day
80	1	16	hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Robert Sams
13. Birthplace New York N.Y.

MOTHER
14. Maiden Name Anna Cadden
15. Birthplace West River Md.

16 (a) Informant Robert Tansill
(b) Address 5605 Wayne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) Filed by registrar NOV 6 1947 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1947, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1947 to Nov. 5 1947 and that I last saw h.e.r. alive on Nov. 4 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Increased Intracranial pressure	
Due to Cerebral Hemorrhage	
Other Conditions Hypertension Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature K. Krulevitz
Address 2116 W. Pratt St. Date signed 11/6/47

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

56660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G56660

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5225- Brookwood Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EARL C. HELZER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife. Rolla Marie Helzer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27-1889

8. AGE: Years 58 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Minneapolis Minn (Town, county, and state)

10. Usual Occupation Electrical Eng.

11. Industry or business Bartgis Bros.

FATHER
12. Name Harry Helzer
13. Birthplace St Paul Minnesota

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Rolla Marie Helzer
(b) Address 5225 Brookwood Rd-26

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8-47 (month) (day) (year)
(c) Cemetery or crematory Chartiers Cemetery
Location Pittsburg Pa

18 (a) Funeral director Milton Schelling -
(b) Address 3914 Hanover St-25

NOV 6 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1947 at 5.10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull -
intracranial Hemorrhage

Due to

Other Conditions Fracture Ribs, right -
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-4-47 at 1.15 p. M.
(b) Where did injury occur? Bartgis Bros- Ilchester, Md. Howard
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell over the wall.

23. Signature Earl L Ryan M.D. Medical Examiner.
Date signed 11-5-47

G56661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G56661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2302 Monticello Rd.
(c) Hospital or institution: 15-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 2302 Monticello Rd.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM JAMES SMITH

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 214-03-6155

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Anita M. Smith (nee Hildebrand) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1896

8. AGE: Years	Months	Days	If less than one day
51	6	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Insurance Mangr.
11. Industry or business Hartford Accident & Indemnity Co.

FATHER
12. Name Frank W. W. Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mollie C. Ortt
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. William J. Smith, Jr. son
(b) Address 3225 Milford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) NOV 6 - 1947 Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1947, at 11:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1947 to Nov 4 1947 and that I last saw h.m. alive on Nov 3 1947.

Immediate cause of death: Coronary occlusion — Duration 2 days
Due to: Coronary disease — Duration 1
Due to:
Other Conditions: See note on back of certificate
(Include pregnancy within 3 months of death)
Date of operation Oct 21/47
Major findings of operation: Cut Cut
Pneumonia (bronchogenic)
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold Drubkoff M. D.
Address 2220 Garrison Blvd Date signed Nov 5/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

566662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 566662

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLY BIEDLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Frank Biedler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1851

8. AGE: Years	Months	Days	If less than one day
96	0	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ross Pennington
13. Birthplace Balto.

MOTHER
14. Maiden Name Sarah Pennington
15. Birthplace Balto.

16 (a) Informant Miss Mary Miller
(b) Address Greenway Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1947, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1947 to Nov. 4, 1947 and that I last saw her alive on Nov. 4, 1947.

Immediate cause of death	Duration
Myocardial Failure	Immediate
Due to Chronic Myocarditis	Months
Due to	
Other Conditions Generalized Arteriosclerosis. (Include pregnancy within 3 months of death)	Years

Date of operation None
Major findings of operations: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature Frank M. Dyson M. D.
Address 2701 N. Calvert St. Date signed Nov. 5-47

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS 150

56663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 656663

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 N. Charles Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 3908 N. Charles St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLY DELL ROBERTSON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	none	female	white	widow

6 (b) Name of husband or wife John L. Robertson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 14, 1872

8. AGE: Years	Months	Days	If less than one day
74	11	20	hr. min.

9. Birthplace Sykesville, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Levi Elder
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza Jane Lilly
15. Birthplace Md.

16 (a) Informant Mr. Frank Robertson
(b) Address 9 Bellemore Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Mausoleum
Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 6 - 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1947 at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Nov. 1947 and that I last saw her alive on Nov 4 1947.

Immediate cause of death	Duration
(a) Cardio-Respiratory failure	1 week
Due to (b) Arterio sclerosis	5 yrs.
Due to (c)	
Other Conditions Diabetes	3 yrs

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frankston E. Lyle M. D.
Address 1104 St Paul Date signed Nov 5, 1947

VS 150

97

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G56664

5664

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 942 N. Washington
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles J. Danzeglock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Margaret T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-77

8. AGE: Years	Months	Days	If less than one day
70	1	15	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name Justus H. Danzeglock
13. Birthplace Germany

MOTHER
14. Maiden Name Mashmont
15. Birthplace Germany

16 (a) Informant Margaret T. Danzeglock
(b) Address 942 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8/47 (month) (day) (year)
(c) Cemetery or crematory Asbury Chapel
Location Reisterstown Md
18 (a) Funeral director Philip Sterling Sons
(b) Address 2014 Gilmore St
19 (a) NOV 6 - 1947 (Date rec'd by registrar) (b) Funeral Home, Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 1947, at 9:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1947 to 11-5 1947, and that I last saw him alive on 11-5-1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Embolus	
Due to	
Other Conditions Ruptured Gangrenous Appendix (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: Ruptured Gangrenous Appendix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Hanaka
Address St Josephs Hosp Date signed 11/5/47

VS 190

4350 94 TYERECK

056665

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

124a

056665 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 months

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Linden (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Dewitt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Tyereck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Christine Tyereck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/10/84

8. AGE: Years 62 | Months 10 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Roumania (Town, county, and state)

10. Usual Occupation operator

11. Industry or business Std. Oil Co.

FATHER
12. Name Paul Tyereck
13. Birthplace Roumania

MOTHER
14. Maiden Name Mary Socin
15. Birthplace Roumania

16 (a) Informant Johns Hopkins Hosp
(b) Address N. Broadway

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 6/47 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cemetery
Location Linden N. J.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Eutaw St

NOV 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5 1947, at 11:58 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1947 to 11/5 1947 and that I last saw him alive on 11/5 1947.

Immediate cause of death	Duration
Cirrhosis of Liver (Laennec)	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marion B. Day M. D.
Address Johns Hopkins Hosp Date signed 6 Nov 47

VS 150

correct age is especially important. Physicians: please write the

G56666

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 61

G56666 Registered No.

Please write the causes of death clearly and legibly. Physicians: please see that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution: Good Samaritan Home 18-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 So. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Cronin

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9th 1879

8. AGE: Years	Months	Days	If less than one day
68	1	27	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name Edward Cronin
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Ireland

16 (a) Informant Mrs Frank Crowe
(b) Address 4205 Gladys Ave Brooklyn, Balt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/47 (month) (day) (year)
(c) Cemetery or crematory St Patricks Cem
Location Binghamton N.Y. Ref.

18 (a) Funeral director Jas. J. Corpening & Son
(b) Address 901-03 Hollins St.

NOV 6 - 1947 (Date rec'd by registrar) (b) Registrar Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5th 1947, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1947 to Nov. 5 1947, and that I last saw her alive on Nov. 5 1947

Immediate cause of death Uremia — Duration 2 Days
Due to Arteriosclerotic disease — Duration years
Due to Diabetes Mellitus — Duration years.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Townsend M.D. M. D.
Address 910 W. Lombard St Date signed Nov 6-47.

V S 190

X

G56667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G56667 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 939 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4637 Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lyng

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas Lyng
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 76 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John McGrath
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna Murphy Sullivan
15. Birthplace Ireland

16 (a) Informant Laurence Lyng (Son)
(b) Address 939 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount & 22nd

19 (a) 6 1947 (Date received by registrar) Thornton Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 1947, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-6 1947 to 11-3 1947 and that I last saw h. CR alive on 11-3 1947

Immediate cause of death: Hypertensive Cardio-vascular disease. — Duration: 5 Yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Special if summer place) While at work?
(e) Means of injury

23. Signature Thos. F. Lyng Jr. M. D.
Address 5217 York Rd Date signed 11-5-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G56668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G56668
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115- Winchester Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GLORIA COLE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/1940

8. AGE: Years 7 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Junior Cole
13. Birthplace Westmoreland Va

MOTHER
14. Maiden Name Ella Smith
15. Birthplace Va

16 (a) Informant Junior Cole
(b) Address 1115 Winchester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Preastman St

19 (a) NOV 6 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1947, at 6.35 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia.
Cerebral Edema
Congestion of Brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Ryan M.D.
Medical Examiner.
Date signed 11-5-47

X

G56669 ✓ G56669

264790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hopkins Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-12-1895

8. AGE: Years	Months	Days	If less than one day
52	7	23	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Carter
13. Birthplace Va ?

MOTHER
14. Maiden Name Betty Montague
15. Birthplace Va ?

16 (a) Informant Alice Carter
(b) Address 825 Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Mrs. H. Kelson
(b) Address 1303 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 4 - 1947 at 3 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3- 1947 to 11-4- 1947 and that I last saw him alive on 11-4- 1947

Immediate cause of death	Duration
Cardiac tamponade	6 Hrs
Due to Ruptured Aorta	6 Hrs
Due to ? Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy Cardiac tamponade

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 4 Nov '47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 6

VS 150

656670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 656670

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 E. Chase St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME MR. THOMAS E. NOEL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1879

8. AGE: Years	Months	Days	If less than one day
68	2	4	..... hr. ..... min.

9. Birthplace Mt. Pleasant Pa. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas C.
13. Birthplace Penna.

MOTHER
14. Maiden Name Agness Oneill
15. Birthplace Penna.

16 (a) Informant Mrs. Edith Smith
(b) Address Hanover Penna.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/47 (month) (day) (year)
(c) Cemetery or crematory Conewago Chapel Pa.
Location.....

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) NOV 6 - 1947 (Rec'd by registrar) (b) Clinton for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5-47 1947, at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1947, to Nov 5 1947, and that I last saw him alive on Nov 5, 1947.

Immediate cause of death	Duration
Gastro-intestinal Hemorrhage & Anemia Chronic & Diabetes.	
Due to Bronchopneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Allan J. Lukinsky M. D.
Address Sinai Hospital Date signed 11-5-47

VS 150

X

56671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1647

Registered No. 56671

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.0.0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Brewer St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1925

8. AGE: Years	Months	Days	If less than one day
22	6	29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Thomas Jones
13. Birthplace Md

MOTHER
14. Maiden Name Lavinia Jones
15. Birthplace Md.

16 (a) Informant Lavinia Jones
(b) Address 1111 Brewer St.

17 (a) Burial (b) Date thereof 11-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National Cemetery
Location Md.

18 (a) Funeral director Adolphus Hartsfield
(b) Address 918 Druid Hill Ave.

19 NOV 6 - 10 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5th 1947, at 10 35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Stab wound of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-5-47 at 9 10 A.M.
(b) Where did injury occur? 2217 Druid Hill Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home of Geo. Pond While at work? no
(d) Means of injury Butcher knife

23. Signature Carl L. Reyer M.D.
Medical Examiner
Date signed 11-6-47

566672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 566672

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Mueller St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Mueller St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANCES STAUB

3 (b) If veteran, name war ----
3 (c) Social Security Account No. -----

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frederick Staub
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1881

8. AGE: Years 66 | Months 6 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Cape Charles, Va. (Town, county, and state)
10. Usual Occupation House-Work
11. Industry or business At Home.

FATHER
12. Name Custis Shay
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Staut
15. Birthplace Va.

16 (a) Informant Leo R. Goetzel (Son)
(b) Address 1106 S. Baylis St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8.-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location German Hill Rd. Balto. Co.

18 (a) Funeral director Charles S. Seiler.
(b) Address 901 S. Conkling St.

19 (Date rec'd by registrar) NOV 6 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1947, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1946 to Nov 5 1947, and that I last saw h. alive on Nov 3 1947.

Immediate cause of death: Cer. Thrombosis
Due to: Arteriosclerosis

	Duration
	1946
	1946

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo R. Goetzel M.D.
Address 3428 Baltimore Date signed Nov. 6-47

V S 150

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100317

56673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. 56673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 N. Carey St (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country.....

3 (a) FULL NAME CHARLES WILLIAMS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	col	single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/15/94

8. AGE: Years	Months	Days	If less than one day
53	1	18	....hr. ....min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name George Williams
13. Birthplace N.C.

MOTHER
14. Maiden Name Georgia Williams
15. Birthplace N.C.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof NOV 6/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A County

18 (a) Funeral director Mrs Robt A. Elliott's Daughter
(b) Address 1129 N Caroline St

19 (a) NOV 6 1947 (Date rec'd by Registrar) (b) Huntington W. Va. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1947, at 11:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13/47 19.. to 11/3 1947, and that I last saw him alive on 11/3 1947.

Immediate cause of death	Duration
Pneumonia, aspiration	
Due to Carcinoma of Esophagus & Esophago-bronchial	
Due to fistula.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work? (Specify type of place)
(e) Means of injury.....

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 4 Nov '47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 56674

56674

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 N. Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 N. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Louis Stallings

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 205-10-7386

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 7, 1889
8. AGE: Years 58 | Months 7 | Days 27 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Trucker
11. Industry or business W. Md. R. R.

FATHER
12. Name Joseph Stallings
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Hammond
15. Birthplace Md.

16 (a) Informant Mrs. Nancy Moore
(b) Address 1806 N. Washington St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/47 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.
18 (a) Funeral director C. J. Fanning & Son
(b) Address 1936 Lafayette Ave.
19 (a) NOV 6 - 1947 (Date rec'd by registrar) (b) Huntington Hilliard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1947 at 6 10 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Nov 1947 and that I last saw him alive on Nov 4 1947.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions Bronchial asthma	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Conrad L. Richter
Address 1706 N. Wash. St Date signed M 11 D 5 47

CONRAD L. X RICHTER, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

556675 D.C. 2-87038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. 556675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. b-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Rose St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY CLAYTON

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1947

8. AGE: Years	Months	Days	If less than one day
2	2	13	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Harry Clayton
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Marie Hudak
15. Birthplace Balto. Md.

16 (a) Informant Harry Clayton
(b) Address 205 N. Rose St.

17 (a) Burial (b) Date thereof Nov. 7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Balto. Md.

18 (a) Funeral director Charles Herwig Sons
(b) Address 2024 Orleans St.

19 NOV 6 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6 1947, at 12:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1947 to 11/6 1947, and that I last saw h[illegible] alive on 11/6 1947.

Immediate cause of death pulmonary edema

Due to hypostatic pneumonia & Left Pulm. Infarct

Due to Pyelonephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Sinai Hosp Date signed 11/7/47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G56676 ✓ G56676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MELVIN P. WOOD

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret E. Wood (nee Beauchamp) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1898

8. AGE: Years 49 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace: New Market, Md. (Town, county, and state)
10. Usual Occupation: Custom Store Keeper
11. Industry or business: U. S. Custom Service

FATHER
12. Name: Joseph M. Wood
13. Birthplace: Md.

MOTHER
14. Maiden Name: Lena Griffith
15. Birthplace: Md.

16 (a) Informant: Mrs. Margaret E. Wood wife
(b) Address: 1714 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National Cem
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) [illegible] (b) Washington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION 3a

20. DATE OF DEATH November 6, 1947, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertrophy, degeneration, and dilatation of heart

Due to: Edema of brain

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George S. Merrill M.D. Medical Examiner.
Date signed 11/6/47

656772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

656677 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 534 E 33rd St. Balto. Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph C Esler
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-12-98
8. AGE: Years 49 | Months 10 | Days 4 | If less than one day ... hr. ... min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John H. Coley
13. Birthplace Maryland (?)

MOTHER
14. Maiden Name Cecelia Hamill
15. Birthplace Maryland (?)

16 (a) Informant Mrs. Irene Whittle
(b) Address 713 W. Lanvale St. Balto. Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director Randall J. Engel
(b) Address 342 N. Highland Ave
19 (a) NOV 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4-47 19... at 7:57 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1947 to 11-4 1947 and that I last saw h/ alive on 11-4 1947

Immediate cause of death
(a) Acute Hepatic insufficiency — Duration: 5 da.
Due to (b) Cirrhosis of Liver — Duration: 1 yr.
Other Conditions Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Norman R. Freeman Jr. M. D.
Address Union Memorial Hosp. Date signed Nov 4 1947

VS 150

Please write correct age is especially important. Physicians: to the causes of death clearly and legibly.

56678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. 56678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 13 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2442- Lakeview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX KATZ

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Idg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Russia.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Chaim
13. Birthplace Russia.

MOTHER
14. Maiden Name Chana
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (b) Date thereof 11-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd.
Location Windsor Mill Rd

18 (a) Funeral director Park Lewis Inc
(b) Address 2100 Eutaw Pl. Balto. Md.

19 (a) NOV 7 - 1947 (b) Jennings for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1947, at 4.47 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet Wound of Brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-5-47 2442- Lakeview Ave. 4.45 P.M.
(b) Where did injury occur? Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D.
Medical Examiner.
Date signed 11-6-47

VS 151

G56679 B.C.# 4-93567

BALTIMORE CITY HEALTH DEPARTMENT

State autonical CERTIFICATE OF DEATH 159

Registered No. G56679

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 738 George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby-boy Byrd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-29-47

8. AGE: Years	Months	Days	If less than one day
			17 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Byrd
13. Birthplace ?

MOTHER
14. Maiden Name Thelma Byrd?
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical Schoo NOV 3 - 1947
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-30-1947, at 6 30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1947 to Oct 30 1947 and that I last saw him alive on Oct 30 1947

Immediate cause of death	Duration
ASPHYXIA VESICULARUM	
Due to ATELECTASIS	
Due to PREMATURITY	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Spencer M.D.
Address Johns Hopkins Hosp Date signed Oct 30 1947
Resident Pathologist

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

B.of H. 92413 ✓

056680

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a

Registered No. 056680

PLEASE WRITE PLAINLY, with pen or pencil, and DO NOT USE DITTO marks. In stating occupation, give the actual work done, even if unemployed at present. Do not use general terms such as laborer, clerk, etc. Be sure that cause of death is stated so as to show the primary cause, secondary cause, and complications, if any, which gave rise to the primary cause, and the duration of each. Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 743 Vine St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Burton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Newborn

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-17-47

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Skilled Labor.
11. Industry or business

FATHER
12. Name Worthie Lee
13. Birthplace North Carolina

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery Johns Hopkins Medical School Oct-31-1947
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 NOV 7 - 1947 (Date rec'd by registrar) Washington White, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17/47, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on 10/17/47 at 8 P. M.

Immediate cause of death	Duration
Pulmonary Atelectasis	
Due to Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Wideman M. D.
Address 1131 Harlem Date signed 10/18/47

VS 150

G56681 BCH 4-9527 BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 161c

Registered No. G56681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bayview Ave & Dukeland St.
(c) Hospital or institution:
West Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Windsor Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby (Girl) Dianna Carlson Clutz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) (Single) married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-31-47

8. AGE: Years — | Months — | Days 2½ | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Richard Gibson Clutz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Snyder
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Geraldine Clutz (mother)
(b) Address 2960 Windsor Ave.

17 (a) ... (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)
(c) Cemetery or Crematory Johns Hopkins Medical Schoo NOV 6 1947
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 NOV 7 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

Please write clearly and fill all items correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31 1947 to 11-2 1947, and that I last saw h. alive on 19

	Duration
Immediate cause of death	
Hemorrhaging	
Due to disease of	
Due to the membrane	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Freiman M. D.
Address W. Balto. Gen. Hosp Date signed 11-4

G56682 B.C.H. 7-92840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G56682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and name town)
(d) Street No. 1014 Stanley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Proctor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 4, 1947

8. AGE: Years | Months | Days | If less than one day: 10 hr. 15 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Jones
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Annie Proctor
15. Birthplace Baltimore, Md.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (Month) (day) 1947 (year)

(c) Cemetery or crematory Johns Hopkins Medical Schoo NOV-6-1947

Location Commissioner of Health

18 (a) Funeral director

(b) Address

19 NOV 7 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1947, at 9 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1947, to Oct. 5 1947, and that I last saw h-er alive on Oct. 5 1947

Immediate cause of death	Duration
Congenital Atelectasis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marie Odom M. D.
Address 2 38 N Caroline St Date signed 10-31-47

Please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

656683 BC A-91980 BALTIMORE CITY HEALTH DEPARTMENT 159 Registered No. 656683

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 Monument St.
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Fullerton-6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8711 Wendell Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boy Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex NB | 5. Color or race wht. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years NB | Months | Days | If less than one day 6 hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thos. P. Harris
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Theresa M. Daniel
15. Birthplace Weston - Haven - Fla

16 (a) Informant Theresa M. Harris
(b) Address 8711 Wendell Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery Johns Hopkins Medical Schoo NOV-5-1947
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 NOV 7 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1947, at 4 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct-17 1947 to Oct-18 1947, and that I last saw him alive on Oct-18 1947.

Immediate cause of death	Duration
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sydney Kurlin, M.D.
Address Sinai Hosp. Date signed 10/30/47

X

Please write the correct age is especially important. Physicians:

B.C# J. 92364

056684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 056684

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 E. Monument St
(c) Hospital or institution Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 25 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto - Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 W. Balto. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years NB. | Months | Days | If less than one day 25 hrs min.

9. Birthplace Balto - Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Stan Carroll
13. Birthplace ?

MOTHER
14. Maiden Name Celma ?
15. Birthplace Texas.

16 (a) Informant Alma Carroll
(b) Address 1037 W. Balto. St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) NOV-5-1947

(c) Cemetery Johns Hopkins Medical Schoo
Location

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 7 - 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1947 at 6 36 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26, 1947 to Oct. 27 1947. and that I last saw him alive on Oct. 27 1947

Immediate cause of death — Duration

Due to Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney Lurie M.D.
Address Sinai Hosp. Date signed 10/30/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

056685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

Registered No. 056685

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave + Madison St
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sallie Ann Holcomb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Garland L. Holcomb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1905

8. AGE: Years 42 | Months 1 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name THOMAS BOYLE
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name SALLIE A. CONROY
15. Birthplace IRELAND

16. (a) Informant MR. THOS. E. BOYLE
(b) Address 4500 LEEDS AVE.

17 (a) BURIAL (b) Date thereof 11/8/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. J. Evans Son Inc
(b) Address 1145 N. Mt. Royal Ave

19 (a) NOV 7 - 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1947, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1947 to Nov. 5 1947, and that I last saw her alive on Nov. 4 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Cardiac Decompensation	
Due to Virus Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Burkhart M. D.
Address MD. General Hosp. Date signed Nov 5, 1947

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G56686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 S Parris D.O.A St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 S Parrish St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

University Medical School NOV-7-1947
Commissioner of Health

18 (a) Funeral director
(b) Address

NOV 7 - 1947
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1947 at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. A. Luberecht M.D.
Medical Examiner.
Date signed 10/23/47

G56687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56687

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

University Medical School NOV-4-1947

Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) NOV 7 - 1947 (Date rec'd by registrar) (b) Tuntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1947, at 4:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.

Date signed 11/27/47

G56688 a.c. # 92187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G56688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs. 5 m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore Catonsville
(If R.F.D. or R.A.D. and give town)
(d) Street No. Redwood & Greene 2819 Walters Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Edmond

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7:25 P.M. 10-29-47

8. AGE: Years | Months | Days | If less than one day: 10 hr. 5 min.

9. Birthplace University Hospital (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Eugene Williams
13. Birthplace Virginia

MOTHER
14. Maiden Name Elsie Edmond
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address 2319 Walters Avenue Catonsville, (21) Maryland.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month, day, year)
(c) Cemetery University Medical School NOV-5-1947
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 NOV 7 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1947 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1947 to Oct. 30 1947, and that I last saw her alive on Oct. 30 1947.

Immediate cause of death Central Anopia — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Lowry M.D.
Address University Hospital Date signed 10-30-47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56689 D.C. # 4-13206 G56689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Maternity Maryland 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs 46 mins
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 Bayard St. Balt. #30
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3:14 Am 11-1-47

8. AGE: Years | Months | Days | If less than one day → 36 hr. 46 min.

9. Birthplace University Hospital. (Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER 12. Name Willie Kennedy

13. Birthplace South Carolina.

MOTHER 14. Maiden Name Frances Olivia Whitney

15. Birthplace Baltimore, Md.

16 (a) Informant Mother

(b) Address 1321 Bayard St. Balt. 30

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery University Medical School NOV-5-1947

Location Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) NOV 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2- 1947 at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3:14 Am 11-1 1947 to 4:00 Pm 11-2 1947 and that I last saw h.i. M alive on 11-2 1947

Immediate cause of death	Duration
Congenital atelectasis	
Due to prematurity (33-wks.)	
Due to Premature Rupture of Membranes	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. E. Lang, Jr.

Address University Md. Hosp. Date signed 11-4 D.
Baltimore, Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656690 AC 47-93263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1612

Registered No. 656690

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Burgundy St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Wright

3 (b) If veteran, name war: 0
3 (c) Social Security Account No. 0

4. Sex: mal
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/31/47

8. AGE: Years 0 | Months 0 | Days 1 | If less than one day: 1 hr. 10 min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Aaron Wright
13. Birthplace Sumerton, South Carolina

MOTHER
14. Maiden Name Louise Hagood
15. Birthplace Sumerton, South Carolina

16 (a) Informant Louise Wright
(b) Address 633 Burgundy St

17 (a) (b) Date thereof
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) NOV 7 - 1947 (Date rec'd by registrar)

University Medical School NOV-5-1947
Commissioner of Health

MEDICAL CERTIFICATION 2:10 PM

20. DATE OF DEATH 10/31/47 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31 19 47 to 10/31 19 47, and that I last saw h[illegible] alive on 10/31 19 47

Immediate cause of death: Atelectasis
Due to: ? Congenital Lues

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: 0
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 0
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Brumback M. D.
Address Date signed

VS 160

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

656691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 656691

PLEASE WRITE PLAINLY, with unfading ink. Erase or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lafayette Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636 Oldham st.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Metzger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Louis Metzger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1886

8. AGE: Years	Months	Days	If less than one day
61	1	25	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Robert J. McGee

13. Birthplace [illegible]

MOTHER: 14. Maiden Name Mary C. Reibert

15. Birthplace Baltimore

16 (a) Informant Louis Metzger

(b) Address 636 S Oldham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8th (month) (day) (year)

(c) Cemetery or crematory 1st UNITED EVAN. U. E. V. Cemetery

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2028 Orleans St

19 NOV 7 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 1947, at 5 3/4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1947 to Nov 5 1947, and that I last saw h[illegible] alive on Nov 5 19 1947

Immediate cause of death Shock Surgical — Duration 18 hrs.

Due to Intestinal resection

Due to Carcinoma of Colon — Known 3 mos.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov 4, 1947

Major findings of operation: Large mass in Colon

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Otis Montgomery M.D.

Address Mercy Hospital Date signed Nov 6/47

VS 150

056692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 056692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 E. 28th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Byer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband: Samuel J. Byer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15th 1864

8. AGE: Years 83 | Months 3 | Days 26 | If less than one day ....hr. ....min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Carl Hennies
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Menzing
15. Birthplace Germany

16 (a) Informant Victoria Lindemuth
(b) Address 202 E. 32nd St.

17 (a) Burial (b) Date thereof 11/10/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Balto. Md.
Location

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 NOV 7 - 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1947 at 9:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Nov 5 1947 and that I last saw h[illegible] alive on Nov 5 1947

Immediate cause of death	Duration
Pulmonary Edema	
Due to Arteriosclerotic Heart Disease & Failure.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Wollenweber M. D.
Address [illegible] University Hosp. Date signed 11-8-47

X

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G56693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G56693

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltor.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? Not (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Webb

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar. 16, 1876

8. AGE: Years	Months	Days	If less than one day
71	7	18	8 hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Unemployed - Newspaper
11. Industry or business

FATHER
12. Name Sam Webb.
13. Birthplace Ellicott City, Md.

MOTHER
14. Maiden Name Laura Martin
15. Birthplace Ellicott City Md.

16 (a) Informant Margaret Webb Fisher
(b) Address Hampden

17 (a) Burial (b) Date thereof 11/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1247 E. Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1947 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1947 to Nov 5 1947 and that I last saw him alive on Nov. 4 1947

	Duration
Immediate cause of death: Carcinomatosis	2 mos. ±
Due to: Bronchogenic Carcinoma	2 mos ±
Due to:	
Other Conditions: Uremia, dehydration, Hypertension, Pancreat Syndrome	

(Include pregnancy within 3 months of death)

Date of operation Oct 1, 1947

Major findings of operation: Nodule biopsy Lg. cell carcinoma.

of autopsy: Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Li Puma M. D.
Address Mercy Hosp. Date signed 11-5-47

VS 150

656694

BALTIMORE CITY HEALTH DEPARTMENT

CMK-115026

CERTIFICATE OF DEATH 46F

Registered No. 656694

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day

(e) Length of stay in Baltimore (yrs., mos., or days) 70 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2111 Allendale Road (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Ella Lambden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James E. (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6-1875

8. AGE: Years	Months	Days	If less than one day
72	2	0	hr. min.

9. Birthplace Virginia, Richmond (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name William Griffis

13. Birthplace Virginia

MOTHER

14. Maiden Name Betty L. Shulton

15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director George W. Little

(b) Address 2700 Edmondson Ave.

19 (a) NOV 7 1947 (Date rec'd by registrar) (b) Washington Witness, M.D. Address

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1947, at 7:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1947 to Nov. 6 1947, and that I last saw h. alive on Nov. 6 1947

Immediate cause of death Generalized carcinomatosis — Duration 7 days

Due to Ca of the gall Bladder — 2 mos

Due to

Other Conditions generalized arterio-sclerosis, Prostatic edema — yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: generalized carcinomatosis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Gordon Craft M.D.

Address Balt. City Hosps Date signed 11/6/47

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G56695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 Hanover St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Teresa Spinnicchia

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 216-05-6368

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: late Francesco

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25 1882

8. AGE: Years 64 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Valguarnera (Town, county, and state) Italy

10. Usual Occupation Seamstress on Vest

11. Industry or business Tailor Shop

FATHER
12. Name Filadelfia Spinnicchia
13. Birthplace Italy

MOTHER
14. Maiden Name Carolina Violetta
15. Birthplace Italy

16 (a) Informant Francesco Augino
(b) Address 1025 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8/47 (month) (day) (year)

(c) Cemetery ~~KENNEDY~~ New Cathedral
Location Baltimore Md.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley St.

19 (a) NOV 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1947 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1947 to Nov. 3 1947 and that I last saw h~~er~~ alive on Nov. 3 1947.

Immediate cause of death: Cardio-Vascular Renal Disease — Duration: 2 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. G. Benesuns M.D.
Address 110 E. Lombard St Date signed 11-6-47

J. G. BENESUNS, MD X

PLEASE WRITE PLAINLY, with ink or indelible pencil. Physicians: please write the causes of death clearly and legibly. Be sure that the information given in items 8 and 9 is complete and correct age is especially important.

VS 150

656696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

656696 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 656 W Fayette St
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 656 W Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Radzevicius

3 (b) If veteran, name war | 3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frank

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 63? | Months | Days | If less than one day: hr. min.

9. Birthplace: Lith.
(Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name ? Vypnauskas
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant: Margaret Cavaselis
(b) Address: 656 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8-47 (month) (day) (year)
(c) Cemetery or crematory: St Stanislaus
Location: Mt. Carmel Rd

18 (a) Funeral director: Joseph Kazanskas Jr
(b) Address: 69 W [illegible]

19 (a) [illegible] 1947 (b) [illegible]
(Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1947 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1947 to Nov 4th 1947 and that I last saw h[illegible] alive on Nov 4th 1947

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to Coronary Sclerosis	Years
Hypertension 220/110	Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. X Cavaselis
Address 651 N. Bentalou Str Date signed 11/4/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56697

205150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

Registered No. 656697

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Dillon st
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) FULL NAME Stanley Mack. ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8/27/31

8. AGE: Years 16 | Months 2 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Henry Mack
13. Birthplace Md

MOTHER
14. Maiden Name Frances Bitter
15. Birthplace Md.

16 (a) Informant Mrs. Frances Mack
(b) Address 2727 Dillon st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9 1947 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Kostka
Location Dundalk Ave

18 (a) Funeral director Marie E. Fiathowski
(b) Address 1000 N. Kenwood Ave

19 (a) NOV 7 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 6 - 1947 19..... at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3 1947 to 11/6 1947 and that I last saw him alive on 11/6 1947.

Immediate cause of death	Duration
Cardiac Failure	
Pulmonary Edema	
Due to Hypertension, arterial	
Due to Chronic Glomerulonephritis	
Other Conditions Lobar Pneumonia, pneumococcal, RLL	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Freeman J. Stephens
Address Johns Hopkins Hosp. Date signed 11/7/47

VS 150

1216

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

G56698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Madison St.
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1747 N. Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Milbourne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1871

8. AGE: Years	Months	Days	If less than one day
76	5	16	15 hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Gladys S. Crapp
(b) Address 1747 Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9/47 (month) (day) (year)
(c) Cemetery or crematory Crisfield Cem.
Location Crisfield Md

18 (a) Funeral director Edwin O. Mitchell
(b) Address 1900 Eutaw Place

19 Nov 7 1947 (Date received by Registrar) (b) at Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1947, at 9:40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1947 to Nov. 6 1947, and that I last saw h.e.r alive on Nov. 6 1947.

Immediate cause of death Respiratory Failure — Duration

Due to Arterio sclerotic Heart Disease

Due to

Other Conditions Senility
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Bruckart M. D.
Address Md. Gen'l Hospital Date signed Nov. 6, 1947

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56699 JL -110426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G56699

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 Francis St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1926

8. AGE: Years 21 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Dave Long
13. Birthplace S. C.

MOTHER
14. Maiden Name Minnie Boyd
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 11-7-47 (month) (day) (year)
(c) Cemetery or crematory Shelton
Location Spartanburg So. Carol.

18 (a) Funeral director William B. Jackson
(b) Address 916 Penna. Ave.

19 (a) NOV 7- 1947 (Date rec'd by registrar) (b) Huntington-Williams Co.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1947, at 7.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947 to Nov. 2 1947, and that I last saw h. alive on Nov. 2 1947.

Immediate cause of death: Cerebral Embolism — Duration 1 Day

Due to Rheumatic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Robinson Jr. M.D.
Address Balt. City Hosp. Date signed 11/5/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 56700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2047 Wheeler Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Conn

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-1639

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Pearl Conn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-3-91

8. AGE: Years	Months	Days	If less than one day
50	4	3	hr. min.

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation Furnisher
11. Industry or business

FATHER
12. Name Harry Conn
13. Birthplace Europe

MOTHER
14. Maiden Name Jennie Rosenfeld
15. Birthplace Europe

16 (a) Informant Pearl Conn
(b) Address 2047 Wheeler ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Hebrew Rest
Location Bowley's Lane

18 (a) Funeral director Sol Kurrmont Bur
(b) Address 1124-26 W Pratt ave

19 NOV 7 – 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1947, at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1947 to Nov. 6 1947, and that I last saw h.im. alive on Oct. 6 1947

Immediate cause of death: Pulmonary Edema — Duration: 7 yrs+
Due to: Hypertensive cardio-vascular disease
Due to:
Other Conditions: Cerebral Hemorrhage
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible], M. D.
Address Johns Hopkins Hosp. Date signed 11-6-47

VS 150

Please write the cause of death clearly and legibly. Physicians: please write correct age in especially important.

656701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 656701

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4118 Ridgewood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannye Berman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife Harry Berman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25 1900

8. AGE: Years	Months	Days	If less than one day
47	7	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Nathan Strauss
13. Birthplace Austria

MOTHER
14. Maiden Name Rose Strauss
15. Birthplace Austria

16 (a) Informant Harry Berman
(b) Address 4118 Ridgewood ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9 47 (month) (day) (year)
(c) Cemetery or crematory Sylvan Washington Blvd
Location Washington Blvd.

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 174-26 W. North ave

19 (a) NOV 7 - 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6/47 19 , at 11 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28/47 19 to 11/6/47 19 , and that I last saw h.e alive on 11/6/ 19 47.

Immediate cause of death Respiratory failure — Duration

Due to Pulmonary Edema

Due to Rheumatic H. Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Friedman M. D.
Address Sinai Hosp Date signed 11/6/47

VS 150

correct age is especially important. Physicians: please write plainly and legibly.

056702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146 B

Registered No. 056702

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2412 E. Monument St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) ✓ City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES STOZEK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Rose (nee Mlynsky)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1882

8. AGE: Years	Months	Days	If less than one day
64	10	6	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation own business
11. Industry or business art leaded glasss

FATHER
12. Name John Stozek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs. Rose Stozek - wife
(b) Address 2412 E. Monument Street

17 (a) Burial (b) Date thereof 11/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

NOV 7 1947 (Date rec'd by registrar) Huntington Willi... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to Nov 6 1947 and that I last saw him alive on Nov 5 1947

Immediate cause of death Carcinoma of Stomach — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide NO
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny M. D.
Address 2700 E Madison St Date signed 11/7/47

VS 190

correct age is especially important. Physicians: please write the

556703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 556703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1541 Division St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1541 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josoph Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1887

8. AGE: Years	Months	Days	If less than one day
60	6		hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation out of work

11. Industry or business

FATHER
12. Name John Hall
13. Birthplace Md

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Md

16 (a) Informant Joseph A Hall
(b) Address 1024 Glenn Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/47 (month) (day) (year)

(c) Cemetery or crematory Athon Md
Location Howard Md. Co

18 (a) Funeral director Sarah L Brown
(b) Address 408 W Montgomery St

19 [illegible] 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1947, at 9.57 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Nov. 4 1947.
and that I last saw h. I. alive on Nov. 4 1947.

Immediate cause of death	Duration
Arteriosclerosis (Generalized)	
Due to	
Due to	
Other Conditions Myocardial failure. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G H Barfield M. D.
Address 722 N. Fulton Ave Date signed Nov 4, 1947

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

VS 150

X

56704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. 56704

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6512 Glen Oak Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6512 Glen Oak Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Foster Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1883

8. AGE: Years 64 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Continental Can Co.

FATHER
12. Name John Foster, Sr.
13. Birthplace Baltimore - Md

MOTHER
14. Maiden Name Annie King
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Lula C. Foster
(b) Address 6512 Glen Oak Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 9 47 (month) (day) (year)
(c) Cemetery or crematory Woodland Mem. Park
Location Joppa Ave.

18 (a) Funeral director Joseph N. Blight Jr.
(b) Address 6009 Harford Road

19 NOV 7 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1947, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1943 to Nov. 6 1947 and that I last saw h. alive on Nov. 6 1947.

Immediate cause of death	Duration
Carcinoma of the Esophagus	4 mos
Diabetes Mellitus	10 yrs
Due to Arteriosclerotic Cardiovascular renal disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 6217 Harford Rd Date signed M. D. 11/7/47

X

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

656705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. 656705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1136 N. Carrollton ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 N. Carrollton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John W. Reeder

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Frances Reeder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1903

8. AGE: Years	Months	Days	If less than one day
44	6	23	hr. min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name George Reeder
13. Birthplace md

MOTHER
14. Maiden Name Ella Timmes
15. Birthplace md

16 (a) Informant Frances Reeder
(b) Address 1136 N. Carrollton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location md

18 (a) Funeral director George H. Kelson
(b) NOV 7 1947 Pressman St

19 (a) (Date rec'd by registrar) (b) Huntington Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1947 to Nov 4 1947 and that I last saw h[illegible] alive on Oct 27 1947

Immediate cause of death	Duration
Valvular Heart Disease	
Due to Aortic Insufficiency	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard M. D.
Address 604 N Bulton Ave Date signed 11/6/47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

656706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

656706
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 N. Morley
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Minersville Pa
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Matthew Griffiths Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Griffiths
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July-11-1875

8. AGE: Years	Months	Days	If less than one day
72	3	25	hr. min.

9. Birthplace Wales
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Jenkins Griffiths
13. Birthplace Wales

MOTHER
14. Maiden Name Harriet Mitchell
15. Birthplace Wales

16 (a) Informant Anna Griffiths
(b) Address 4 N. Morley St.

17 (a) Burial (b) Date thereof 11-9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Family Lots
Location Minersville - Pa

18 (a) Funeral director Edw. F. McNabb
(b) Address Medford Wade Ave

NOV 7 - 1947 (b) Huntington Williams, Registrar
(Date received) (Signature)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 1 1947 to Nov. 5 1947 and that I last saw h[illegible] alive on Nov. 5 1947

Immediate cause of death CORONARY THROMBOSIS — Duration

Due to ARTERIOSCLEROTIC C.V.D.

Due to

Other Conditions ANTRACOSIS.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Brunt M. D.
Address 33 E. FREDERICK RD Date signed 11/6/47

Please correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B. C#

G56707 J-9388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. G56707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Balt. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5100 Brookwood Rd; Balt (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Baby Girl Barnes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/29/47

8. AGE: Years | Months | Days 0 | If less than one day 13 hr. 55 min.

9. Birthplace Balt. Co. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Edward Barnes
13. Birthplace Balt, Md.

MOTHER
14. Maiden Name [illegible] Marie Knabusik
15. Birthplace Checko Slovakia

16 (a) Informant mother
(b) Address 5100 Brookwood Rd. Balt.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory University Medical School NOV-5-1947
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) NOV 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29 1947, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1947 to 10/29 1947, and that I last saw her alive on 10/29 1947.

Immediate cause of death	Duration
Congenital Atelectasis	
Due to	
Due to	
Other Conditions Hydrocephalus, subdural hemorrhage, pleural effusion (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William B. Cooper Jr. M. D.
Address Sand Balto Gen Date signed 11/3/47

Instructions: Please write the correct age in years, months, days, hours, minutes. Physicians: please write the causes of death clearly and legibly. Underlining is especially important.

VS 150

161a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

656708 656708 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1432 N. Broadway
(c) Hospital or institution: 9 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adolph Ernest Gerndt

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 217-03-9484

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Mary Irene Gerndt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1873.

8. AGE: Years	Months	Days	If less than one day
74 72	0	3	hr. min.

9. Birthplace Newark, N. J. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Union Liberty

FATHER
12. Name Charles Gerndt
13. Birthplace Newark, N.J.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Mary I. Gerndt
(b) Address 1432 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (Date rec'd by Registrar) NOV 7 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1947, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947, to Nov. 1947, and that I last saw him alive on Oct 31 1947.

Immediate cause of death	Duration
Acute Cardiac dilatation	
Due to Cardiac decompensation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles E. MacMenamin M. D.
Address 2911 E. Balto. St. Date signed Nov 5 1947

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. 656709

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 211 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Wesley Cassedy

3 (b) If veteran, name war	3 (c) Social Security Account No.
SAW	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorce
M	W	Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1878

8. AGE: Years	Months	Days	If less than one day
69	2	18 28	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm. Cassedy
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Balto, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 11-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext.
18 (a) Funeral director Lloyd Zeiler Inc.
(b) Address 403 S. Bond St.
19 NOV 7 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1947, at 7:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 9 1947 to Nov. 6 1947 and that I last saw him alive on Nov. 6 1947

	Duration
Immediate cause of death Carcinoma, squamous cell right ear with extension to right external auditory canal	1 yr-7mo
Due to: Carcinoma, basal cell, nose	1 yr.
Due to: Carcinoma, basal cell left lower eyelid	1 yr.
Other Conditions Pneumonia, bronchial left lower lobe (Include pregnancy within 3 months of death)	1 wk
Date of operation Hypertrophy	
Major findings of operation: prostatic benign (unknown duration)	
Date of autopsy: As above	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. van Ackeren, Medical Director
Address Medical Officer in Charge Signed 11/7/47

V S 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G56710

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 Fellington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Fellington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Goldie D. Duering

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Paul D. Duering

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19-1884

8. AGE: Years 63 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md. (State, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Charles Hobbs
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances Myers
15. Birthplace Maryland

16 (a) Informant Paul D. Duering
(b) Address 800 Fellington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Fpells Road

19 NOV 7 - 1947 (Date rec'd by registrar) (b) Huntington White Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6- 1947, at 10 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1947 to Nov. 6 1947, and that I last saw h[e] alive on Nov. 6 1947

Immediate cause of death	Duration
Chronic Myocarditis with Decompensation.	10 Yrs.
Due to Diabetes Mellitus	8 Yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J W Keown M.D.
Address 1938 Linden Ave Date signed 11/7/47

correct age is especially important. Physicians: please write the c[ause]s of death clearly and legibly.

56711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G56711

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4302 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4302 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emory Vinton Gladfelter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lydia Florence Gladfelter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27-1860

8. AGE: Years	Months	Days	If less than one day
87	3	9	hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)
10. Usual Occupation Pattern Maker
11. Industry or business

FATHER
12. Name Reuben Gladfelter
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Rowe
15. Birthplace Maryland

16 (a) Informant Mrs. Lydia Florence Gladfelter
(b) Address 4302 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8-1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3634 Falls Road

19 (a) NOV 7 - 1947 (Date rec'd by registrar) (b) Huntington Willis Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6- 1947, at 4:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 19 47 to Nov 6 19 47, and that I last saw him alive on Nov. 4 19 47

Immediate cause of death	Duration
Arteriosclerotic C.V. Dis	
Due to	
Due to	
Other Conditions Hypostatic Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward L. Thurman M.D.
Address 4037 Falls Rd Date signed 11/6/47

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. 656712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714- E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH SCHRIEFFER (or) Schriefer

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-05-9866

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Nov. 15 1879

8. AGE: Years 67 | Months 11 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Basto (Town, county, and state)

10. Usual Occupation Proseser

11. Industry or business Panzer Co.

FATHER
12. Name Henry Schrieffer
13. Birthplace Austria.

MOTHER
14. Maiden Name Barbara Kriss
15. Birthplace Basto.

16 (a) Informant Fannie Schrieffer
(b) Address 1714 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 8 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St

18 (a) Funeral director Dent & Co. Diggs & Sons
(b) Address NOV 7 1947 S. Ann St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1947, at 8.30 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11-6-47

VS 151

X

6713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 56713

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Bagdon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband John J. Bogdan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR-25 1896

8. AGE: Years	Months	Days	If less than one day
51	7	17	hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace Lithuania

MOTHER
14. Maiden Name
15. Birthplace Lithuania

16 (a) Informant John J. Bogdan
(b) Address 611 W. Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road.

18 (a) Funeral director Charles W. Kackmeister
(b) Address 703 McHenry St.

19 (a) NOV 7 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1947, at 12:15 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Ryan M.D. Medical Examiner
Date signed 11-4-47

5714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 65714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM R. BOLGIANO

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ida E. Bolgiano
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1859

8. AGE: Years	Months	Days	If less than one day
88	10	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Captain
11. Industry or business Baltimore Fire Dept.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Ida E. Bolgiano
(b) Address 2015 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1947, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1947 to Nov 6 1947, and that I last saw him alive on Nov 5 1947

Immediate cause of death	Duration
Cardiac failure	2 days
Due to Broncho. pneumonia (terminal)	23 days
Due to Arteriosclerosis	5 yrs a Man
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lantz M. D.
Address Temple Garden Apts Date signed Nov 7-47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G56715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 Powers St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 833 Powers St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES T. SWAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
Civil War	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Laura B. Swan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1850

8. AGE: Years	Months	Days	If less than one day
97	1	20	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Retired Cobbler
11. Industry or business

FATHER
12. Name George Swan
13. Birthplace England

MOTHER
14. Maiden Name
15. Birthplace England

16. (a) Informant Mrs. Gertrude Hubbach
(b) Address 3026 Windsor Ave

17 (a) Burial (b) Date thereof 11/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) NOV 7 - 1947 (b) Huntington Hollins Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1947, at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1947 to Nov 5 1947, and that I last saw h[illegible] alive on Nov 3 1947.

Immediate cause of death	Duration
(a) Cardiac failure	4 hrs.
Gangrene of right foot	10 days
Due to (b) Femoral arterio-sclerosis	15 Yrs.
Due to (c) —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Isaac Dreifuss
Address 836 W 36 St Date signed 11/6/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. 56716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lenox Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Mc Elderry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Addie M. Jones (Jones)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Birdie E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/869

8. AGE: Years 60 | Months 8 | Days 30 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. L. Tregoe
13. Birthplace Maryland

MOTHER
14. Maiden Name Lola Gore
15. Birthplace Maryland

16 (a) Informant Francis Jones
(b) Address 3003 McElderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 10 (day) 47 (year)
(c) Cemetery or crematory Oaklawn
Location 7725 Eastern Ave

18 (a) Funeral director John A Moran
(b) Address 3040 E. Balt. St.

19 NOV 8 - 1947 (Date rec'd by registrar) Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1947, at 840 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1947 to Nov 6 1947 and that I last saw h[illegible] alive on Nov 6 1947.

Immediate cause of death	Duration
Pulmonary Embolus,	
Due to	
Due to	
Other Conditions Cholecystitis Chronic appendicitis (Include pregnancy within 3 months of death)	

Date of operation Oct 27, 1947

Major findings of operation: Chronic cholecystitis, cholelithiasis, chronic appendicitis

Findings of autopsy: Pulmonary embolus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard S Cohen M.D.
Address Lenox Hospital Date signed Nov 7 47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

556717 OC-C9814 BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 556717

No. 114848 CERTIFICATE OF DEATH 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2512 Raynor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy (Dix (Geraldine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct /29/ 1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name Geraldine

15. Birthplace

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Cremated (Burial, cremation, removal) (b) Date thereof 11-6-47 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Balto City Hosp
Location 4940 Eastern Ave

18 (a) ~~Funeral director~~ Balto City Hosp
(b) ~~Address~~ Records

19 (a) NOV 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30th 1947 19..., at 6.50 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29th 1947 to Oct 30th 1947 and that I last saw him alive on Oct 30th 1947

Immediate cause of death: Premature ity — Duration: 1 Day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas H Becker M.D.
Address Date signed 11/6/47

VS -150

· correct age is especially important. Physicians: please write the cause of death clearly and legibly.

656718 BC-C 9814 BALTIMORE CITY HEALTH DEPARTMENT ✓ 656718
LW 114849 CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2512 Raynor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Baby Girl, Dix. (Geraldine)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-29-47

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Geraldine
15. Birthplace

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 11-6-47
(Burial, cremation, removal) (month) (day) (year)
(c) crematory Balto. City Hosp
Location 4940 Eastern Ave

18 (a) Funeral director Balto City Hosp
(b) Address Records

19 (a) NOV 8 - 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2- 1947 at 3:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1947 to Nov. 2- 1947 and that I last saw h er alive on Nov. 2 1947

Immediate cause of death: Prematurity — Duration: 5d

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold A Becker
Address Balto City Hosp Date signed 11/8/47

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

X

56719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49c

Registered No. G56719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 N. Glover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 N. Glover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adelaide L. Bien

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-26-5658

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Geo. J. Bien

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16-1892

8. AGE: Years 55 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Lord Balto Laundry

FATHER 12. Name Herman Voelker

13. Birthplace Ger.

MOTHER 14. Maiden Name Susanna Koehler

15. Birthplace Ger.

16 (a) Informant Mrs. Maggie Miller

(b) Address 533 N. Glover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10 47 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore

18 (a) Funeral director Philip Herwig Sons

(b) Address 2024 Orleans St

19 (a) NOV 8 1947 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1947, at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947 to Nov 5 1947, and that I last saw h/e alive on Nov 5 1947

Immediate cause of death	Duration
Carcinoma of vagina & vulva & generalized metastasis	9-2-47
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence None at M

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. Schumacher M. D.

Address 542 S. Ex Pl Date signed 11-6-47

correct age is especially important. Physicians: please write the

V S 150

67/20

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 656720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES B. WELLS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mabel B. Wells

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3rd 1882

8. AGE: Years	Months	Days	If less than one day
65	9	4	hr. min.

9. Birthplace Buffalo N. Y.
(Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business Own Business

FATHER
12. Name Wells
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Mabel B. Wells
(b) Address 205 W. Saratoga St

17 (a) Burial (b) Date thereof 11/10/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc.
(b) Address 6007 St. Paul St.

19 (a) NOV 8 1947
(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1947, at 8 a. M

21. I certify that I took charge of the remains described above, held an insp. & inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Kruger M.D.
Medical Examiner.
Date signed 11-7-47

VS 151

G56721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

Registered No. G56721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 N. DALLAS St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8/6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 N. DALLAS St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard N. COLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Widowed

6 (b) Name of husband or wife ETHEL (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-13-1884

8. AGE: Years	Months	Days	If less than one day
63		23	hr. min.

9. Birthplace BALTO. Md.
(Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name CHARLES A. COLE
13. Birthplace Md

MOTHER
14. Maiden Name HENRIETTA KEY
15. Birthplace Md

16 (a) Informant FANNIE N. WILSON
(b) Address 1927 RUTLAND AVE

17 (a) BURIAL (b) Date thereof 11-9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ARBUTUS MEM
Location

18 (a) Funeral director Joseph B. Lodi
(b) Address 1136 N. Central Ave

19 (a) NOV 8 - 1947 (b) Huntington Williams Md
(Filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1947 at 3.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1947 to Nov 5 1947 and that I last saw him alive on Nov 4 1947

Immediate cause of death
(a) Strangulation — Duration

Due to Progressive Bulbar Palsy — April 1947

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. K. Calhoun M. D.
Address 2223 E. Preston Date signed

VS 150

X 11-7-47

To the undertaker: Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

556722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 556722

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 633 W. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY [illegible] JACKSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife James Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1890

8. AGE: Years	Months	Days	If less than one day
57	8	18	hr. min.

9. Birthplace Denwood, Virginia
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Oliver
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Peace
15. Birthplace Va.

16 (a) Informant Mr. James Jackson
(b) Address 633 W. Biddle St.

17 (a) Burial (b) Date thereof 11-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. [illegible]
(b) Address 578 W. Biddle St.

19 NOV 8 - 1947
(Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 6, 19 , at 5:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1947 to 11-6 1947 and that I last saw h[illegible] alive on 11-5 1947.

Immediate cause of death	Duration
Cardio-Renal-Vas Cular, Syndrome,	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature B. [illegible]
Address 1[illegible] Date signed 11/8/47

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 56723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 Robert St.
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Robert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE R. PETTIGREW

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Lexington, Virginia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Pettigrew
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Adams
15. Birthplace Va.

16 (a) Informant Mr. Clarence Wheeler
(b) Address 420 Robert St.

17 (a) Burial (b) Date thereof 11-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 NOV 8 - 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1947, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Nov. 1947 to 6 Nov. 1947, and that I last saw h/m alive on 6 Nov. 1947.

Immediate cause of death	Duration
Acute Coronary Occlusion	1 day
Due to	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Stanford D. Immerman M. D.
Address 2309 Druid Hill Ave Date signed 11-7-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

94a

G56724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G56724

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2771 W. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES HARMON McGOVERN

3 (b) If veteran, name war

3 (c) Social Security Account No. 079-16-1593

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife: Lois A. Harmon, McGovern nee North
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1910

8. AGE: Years	Months	Days	If less than one day
36	11	23	....hr. ....min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Jockey

11. Industry or business

FATHER
12. Name James Harmon McGovern
13. Birthplace Sheepshead Bay Brooklyn

MOTHER
14. Maiden Name Louise J. Brunner
15. Birthplace Brooklyn, N. Y.

16 (a) Informant Mrs. Mabel A. Jones
(b) Address 2771 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1947, at 2 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemothorax left
Due to Rupture of left lung
Other Conditions Fracture, left ribs 4-9 inclusive, Bronchopneumonia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27/17
(a) Date of injury 10-31-47 at 2 p. M.
(b) Where did injury occur? Pimlico Race Track Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from horse

23. Signature Carl L. Kreyer M.D.
Medical Examiner
Date signed 11-7-47

VS 151

~~4567~~25

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

Registered No. 567725

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 West North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Racusin

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-0135

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: Laborer
11. Industry or business

FATHER
12. Name: William Racusin
13. Birthplace: Russia

MOTHER
14. Maiden Name: Jesse ?
15. Birthplace: Russia

16 (a) Informant: Miss Geraldine Racusin
(b) Address: 1925 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 9, 1947 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Washington Road
Location: Washington Blvd

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 NOV 8 - 1947 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1947, at 2:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Angina Pectoris

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Earl L. Royer M.D. Medical Examiner.
Date signed 11-7-47

VS 151

[redacted]

Med. Exam. Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 0567726

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town 607 W. 40th St. (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 W. 40th St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Herbert McGwathmey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth Gwathmey
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 8/22/96

8. AGE: Years	Months	Days	If less than one day
51	2	16	....hr. ....min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Sales Mgr
11. Industry or business

FATHER
12. Name Robert Gwathmey
13. Birthplace Va

MOTHER
14. Maiden Name Harriet Winston
15. Birthplace Va

16 (a) Informant Mrs. Eliz. S. Gwathmey
(b) Address 607 W. 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9/47 (month) (day) (year)
(c) Cemetery or crematory Hollywood Cem.
Location Richmond Va

18 (a) Funeral director John O. Mitchell Sons
(b) Address 900 Eutaw Place

NOV 8 – 1947 (Date rec'd by registrar) (By) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 7 – 1947, at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1947, to Nov 7 1947, and that I last saw h[illegible] alive on Nov 7 1947.

Immediate cause of death Myocardial Infarction
Due to Coronary Artery Disease
Due to .....
Other Conditions.....
(Include pregnancy within 3 months of death)

Duration 18 hrs.

Date of operation —
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ....M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature [signature] M.D.
Address [illegible] Date signed 11-7-47

correct age is especially important. Physicians: please write the causes of death clearly and correctly.

~~567727~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. 567727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3726 Gough Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days): 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3726 Gough Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WILLIAM McLAIN

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-05-7672

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary A. Corkran

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1908

8. AGE: Years 39 | Months 8 | Days 24 | If less than one day: hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation

11. Industry or business Baltimore Transfer Co.

FATHER
12. Name John H. McLain
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Eva C. Leverle
15. Birthplace Germany

16 (a) Informant Mrs. Mary A. McLain
(b) Address 3726 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 NOV 8 1947 Huntington Williams M.D.
(Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1947, 5.20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1941, to Nov 6 1947, and that I last saw him alive on Nov 5 1947.

	Duration
Immediate cause of death: Coronary thrombosis	1 hr.
Due to: Coronary arteriosclerosis	
Due to:	
Other Conditions: Rheumatic heart disease. (Include pregnancy within 3 months of death)	5 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place; in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Gorsch M. D.
Address 147 N Eutaw Date signed 11-7-47

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59728

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 656728

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town York (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. #6 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Lydia E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1884

8. AGE: Years	Months	Days	If less than one day
63	9	11	hr. min.

9. Birthplace Berks Co., Pa.
(Town, county, and state)

10. Usual Occupation Antique Dealer

11. Industry or business Antique Business

FATHER
12. Name Wm Stevenson
13. Birthplace York Co, Pa

MOTHER
14. Maiden Name No Record
15. Birthplace No Record

16 (a) Informant Franklin A Stevenson
(b) Address R.D. #5 York Pa.

17 (a) Burial (b) Date thereof Nov 10, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location York, Pa. CREEP

18 (a) Funeral director Guy B. Creep
(b) Address York, Pa

NOV 8 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1947, at 1 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Royer M.D.
Medical Examiner
Date signed 11-7-47

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 V

Registered No. 567739

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division ST
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country No

3 (a) FULL NAME Lewis Dickerson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 58 Months Days If less than one day hr. min.
9. Birthplace Edenton N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business Labor.

FATHER
12. Name Sampson Dickerson
13. Birthplace NC

MOTHER
14. Maiden Name Mary J Henton
15. Birthplace NC

16 (a) Informant John A Dickerson
(b) Address 1225 Myrtle Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8th 47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Edgar O Wilson
18 (a) Funeral director
(b) Address 1000 Bloomberg
NOV 8 1947 (Date filed) (b) Huntington for Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4 1947 at 6.05 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1947 to 11/4 1947 and that I last saw him alive on 11/4 1947.

	Duration
Immediate cause of death: PULMONARY CONGESTION	?
Due to: ARTERIOSCLEROTIC	
Due to: Cardio-Vascular Disease	
Other Conditions: MALNUTRITION	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William Garner M. D.
Address 514 Division St Date signed 11/4/47

VS 150

correct age is especially important. Physicians: please write

X

56730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 56730

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Fullerton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8717 Wendell Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Frederick Seiler

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No. ---

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Bessie ?
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1888

8. AGE: Years 58 | Months 11 | Days 25 | If less than one day ___ hr. ___ min.

9. Birthplace: Balto, Md.
(Town, county, and state)
10. Usual Occupation: Janitor
11. Industry or business:

FATHER
12. Name: Charles O. Seiler
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna Maria Wenzel
15. Birthplace: Frederick, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10 1947 (month) (day) (year)
(c) Cemetery or crematory: Balto. Natl. Cem.
Location: Balto. Md.

18 (a) Funeral director: Lasahn Funeral Home
(b) Address: 4401 Belair Rd.

19 (a) NOV 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 190

correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1947, at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1947 to Nov. 6 1947 and that I last saw h[illegible] alive on Nov. 6 1947.

Immediate cause of death	Duration
Pneumonia, lobar	
Right lower lobe	
Abscesses, cortical right kidney	
Due to hydronephrosis, pyonephrosis right, hydronephrosis, left	
Due to Hydrourater, bilateral	
due to vesical neck obstruction	
Other Conditions due to hypertrophy prostate	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Others: Encephalomalacia, left temporal lobe, sigmoid colon diverticulitis-sigmoido-appendicitis
Was autopsy? As Above Fistula

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Stinson M. D.
Address Marine Hosp. Balto. Date signed 7 Nov. 1947

X

656731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 656731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1036 Brentwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 Brentwood (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara E. Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Horton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Aug. 7- 1859~~

8. AGE: Years 88 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace Mill Run, Pennsylvania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER | FATHER

12. Name John Bigam

13. Birthplace Pennsylvania

14. Maiden Name Eliza Harbaugh

15. Birthplace Pennsylvania

16 (a) Informant James Patterson

(b) Address 1036 Brentwood Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 8-47 (month) (day) (year)

(c) Cemetery or crematory to Cumberland, Md.

Location

18 (a) Funeral director Wm. Cook, Inc.

(b) Address 1217 St. Paul Street.

19 (a) NOV 8 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24 1947 to 11/7 1947, and that I last saw h[illegible] alive on 11/7 1947

Immediate cause of death	Duration
Cerebral hemorrhage	48 hrs
Due to Hypertension and Cardiovascular disease	7 wks
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. N. MacMurchy M. D.
Address 81 Buren St Balto. Md Date signed 11/7/47

VS 150

56732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 656732

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Wortonia Rd.
(c) Hospital or institution: The Mount Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 21 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Catherine Gustafsson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Nils G. Gustafsson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1892

8. AGE: Years 56 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Buffalo, N. Y.
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name John G. Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Schneider
15. Birthplace Germany

16 (a) Informant Mr. Nils G. Gustafsson
(b) Address 1631 Fleet St.

17 (a) Removal (b) Date thereof Nov. 8/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Acacia Park
Location Buffalo N.Y.

18 (a) Funeral director Harry H. Nuttle
(b) Address 4101 Edmondson Ave.

19 (a) Nov 8 1947 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7/47. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947, to Nov 1947, and that I last saw h. alive on 11/7 1947.

Immediate cause of death	Duration
Sarcoma of breast	1 yr
Metastases to lung	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Nov. 26
Major findings of operation: Sarcoma breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Ed. A. Hurley M.D.
Address 2426 Eutaw Pl. Date signed 11/8/47

VS 150

X

Please write plainly. Physicians: please write the correct age in especially important.

656733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. 656733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street 809 W. University Parkway (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jeremiah Pattison Travers

3 (b) If veteran, name war: WWI
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Alice Kemp Travers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1895

8. AGE: Years	Months	Days	If less than one day
52	2	5	hr. min.

9. Birthplace Dorchester Co. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm. Travers
13. Birthplace Dorchester Co. Md.

MOTHER
14. Maiden Name Hattie Spillman
15. Birthplace Dorchester Co. Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10 '47 (month) (day) (year)
(c) Cemetery or crematory Leon Cathedral
Location Old Frederick Rd
18 (a) Funeral director Harry A Wilson
(b) Address 4101 Edmondson Ave
19 NOV 8 1947 (Date rec'd by Registrar) Torrington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1947, at 5:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1947 to Nov. 7 1947 and that I last saw him alive on Nov. 7 1947

Immediate cause of death	Duration
Laennec's cirrhosis of liver with ascites	6 mos.
Due to	
Due to	
Other Conditions. Gastric ulcer, Duodenal ulcer (Include pregnancy within 3 months of death)	Unknown

Date of operation
Major findings of operations:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

22. Signature J. A. van Ackeren, Medical Director
Address Medical Officer in charge Signed 11/7/47

correct age is especially important. Physicians: please write

V S 150

656734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 656734

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223- Westowne Road.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME TERESA LOWREY

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-9875

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1900

8. AGE: Years	Months	Days	If less than one day
47	7	19	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business A & P Tea Co

FATHER
12. Name J. Frank Lowrey
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary T. Leonard
15. Birthplace Md

16 (a) Informant Miss Ella Leonard
(b) Address 223 Westowne Rd

17 (a) Burial (b) Date thereof Nov 10 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mem Catholic
Location Old Frederick Rd

18 (a) Funeral director Harry H Weyler
(b) Address 4101 Edmondson Ave

19 NOV 8 - 1947 (b) Huntington Williams Mgr.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1947, at 4.50 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary embolism

Due to.....

Other Conditions Fractured, right ankle
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-5-47 at ? 9 a. M. 28/4
(b) Where did injury occur? 223 Westowne Rd. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell to floor

23. Signature [signature] M.D.
Medical Examiner

Date signed 11-7-47

VS 181

656735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. 656735

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST. AND RUTLAND AVE.
(c) Hospital or institution: SINAI HOSP. 5th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 N. FRONT ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOLOMON FELDSHER

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: CELIA
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1859
8. AGE: Years 88 | Months | Days | If less than one day hr. min.
9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation
11. Industry or business NONE

FATHER
12. Name ELY FELDSHER
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ANNA ?
15. Birthplace RUSSIA

16 (a) Informant Mrs. Celia Feldsher
(b) Address 8 N. Front St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 9 47 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location 3600 E. BALTIMORE ST.

18 (a) Funeral director Sol LEVINSON & BROS
(b) Address 1124-26 W. NORTH AVE.

19 (a) 1947 (b) Received by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1947, at 1:18 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1947 to 11-9 1947 and that I last saw HIM alive on 11-9 1947

Immediate cause of death SHOCK — Duration 36 HRS.

Due to POSTOPERATIVE HEMORRHAGE

Due to PROSTATECTOMY

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-7-47.

Major findings of operation: BENIGN HYPERTROPHY OF PROSTATE

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Lerman, M.D.
Address Sinai Hospital Date signed 11-9-47

I certify the above is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G56736 53 Jack Singer 506 E. North Ave Bal 3737 Fe 2016

BALTIMORE CITY HEALTH DEPARTMENT ✓ G56726 Registered No.

CERTIFICATE OF DEATH 83B

7600 York Road or

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 N. Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie M. Capel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband William H. Capel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 14th 1866

8. AGE: Years: 81 | Months: 9 | Days: 24 | If less than one day: hr. min.

9. Birthplace Kent Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name William H. Brady
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline ?
15. Birthplace Germany

16 (a) Informant Mrs. Augusta Lee
(b) Address 1714 N. Calvert St.

17 (a) Removal (b) Date thereof 11/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chestertown
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar)

9 - 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 1947, at 1:21 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Nov 8 1947 and that I last saw her alive on Nov 7 1947.

Immediate cause of death	Duration
cerebral thrombosis	
Due to generalized arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack J. Singer M. D.
Address 506 E. North Ave Date signed 11/9/47

X

Book 3-93395
656737

BALTIMORE CITY HEALTH DEPARTMENT ✓ 656737 Registered No.
CERTIFICATE OF DEATH 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4408 Ivanhoe Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4408 Ivanhoe Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Henry Betty L. Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, ~~married, widowed, or divorced.~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7 1947

8. AGE: Years | Months | Days | If less than one day 12 hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Lawrence B. Henry
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Betty L Tomkins
15. Birthplace England

16 (a) Informant Anna Henry
(b) Address 529 Willow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10 1947 (month) (day) (year)
(c) Cemetery or crematory St Stephens
Location Bradshaw Md

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) 1947 (Registered by registrar) (b) Huntington Williams, M.D.

NOV 8

151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/47 19 at 5:20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis, neonatorum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 11/8/47

X

G56738 ✓ G56738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 W. 25th St Dist.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 W. 25th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Legum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Philip Steele

13. Birthplace Russia

MOTHER 14. Maiden Name Rosie

15. Birthplace Russia

16 (a) Informant Samuel Legum

(b) Address 130 W 25 St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-47 (month) (day) (year)

(c) Cemetery or crematory

Location Nebraw Herzug Cem

18 (a) Funeral director Jack Lewis Inc

(b) Address 2106 Eutaw Place

19 1947 (b) (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 19 47 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive a v disease
Fr Diabetes Mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 11/10/47

656739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

656739 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible] N. BROADWAY
(c) Hospital or institution:
CHURCH HOME & HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3522 Green Spring Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES COHEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	W	MARRIED

6 (b) Name of husband or wife Gertrude
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10/1902

8. AGE: Years	Months	Days	If less than one day
45	1		hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name HARRY COHEN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name HARDEN, ELSIE
15. Birthplace RUSSIA

16 (a) Informant SWARTZ, MRS NETTIE
(b) Address 15 N. BROADWAY BALT, 31, MD
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel
18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place Huntington Williams, MD
19 (a) [illegible] (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1947, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1947 to Nov 8 1947, and that I last saw h[illegible] alive on Nov 6 1947.

Immediate cause of death	Duration
RESPIRATORY FAILURE	?
SECONDARY Due to BRAIN STEM HEMORRHAGE (PROBABLE)	?
Post OPERATIVE TO REMOVAL OF RUPTURE INTERVERTEBRAL DISC	1
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10-6-47
Major findings of operation: RUPTURED INTERVERTEBRAL DISC - CERVICAL
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John M. Adler M. D.
Address BALT 24 MD Date signed 11-8-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

656740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

656730 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel D. London

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27-1883

8. AGE: Years 64 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Rebecca London

(b) Address 1625 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location Jack Lewis Inc

18 (a) Funeral director 760 Eutaw Place

(b) Address

19 (a) (Date received by registrar) (b) Registrar

NOV 9 1947

V S 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/1947, at 9:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to 11/7/1947, and that I last saw alive on 11/7/1947.

Immediate cause of death Obstruction Bowel
Cardiac - Vascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Frankel M. D.

Address 1422 Park Ave Date signed 11/7/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-022
J-93675 656721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160a

Registered No. (656721)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 204 E. 20th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mildred Anne Young

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11/7/47

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: —

FATHER
12. Name: Thomas H. Young
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mildred Anna Conley
15. Birthplace: W. Va.

16 (a) Informant: Mr. Thomas Young
(b) Address: 204 E 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-10-47 (month) (day) (year)
(c) Cemetery or crematory: Western Cem
Baltimore Md

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Rd.

19 (a) 1947 (Date rec'd by registrar) (Signature for the Registrar) Registrar

NOV 9

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/8/47 19..., at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7 1947 to 11/8 1947, and that I last saw her alive on 11/8 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to: Intracranial Hemorrhage	
Due to:	
Other Conditions: Prematurity	

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Anthony F. DiPaula M.D.
Address: St. Joseph's Hosp. Date signed: 11/8/47

VS 190

Correct age is especially important. Physicians: please write

656742

335589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 74a

656742 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Arabia Ave (If rural give location)
(e) Citizen of foreign country? Nat. (Yes or No) If yes, name country

3 (a) FULL NAME Sophia E. Elgert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	W.	married

6 (b) Name of husband or wife Harry E. Elgert
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 6/9/79

8. AGE: Years	Months	Days	If less than one day
68	4	28	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Hswife
11. Industry or business

FATHER
12. Name Frederick Krumreine
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Hutter
15. Birthplace Md

16 (a) Informant Mr. Harry Elgert
(b) Address 4502 Arabia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-47 (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Balto

18 (a) Funeral director Longnecker & Luck
(b) Address 5305 Harford Rd.

19 (a) 1947 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1947 19 , at 1045 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1947, to 11/6 1947. and that I last saw her alive on 11/6 1947.

Immediate cause of death	Duration
(1) Malnutrition,	
Antecedent cause, if any, due to (2) Chronic Lymphoid Leukemia	
Due to (3) Enterocolitis, general Lipoid	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman E. Shafer, M. D.
Address The Johns Hopkins Hospital Date signed 11-6-47

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

656743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

656743 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Arkeney Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Fitzpatrick
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: S.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 6, 1886
8. AGE: Years 61 | Months 6 | Days 1 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Philip Joseph Fitzpatrick
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine Hubbard
15. Birthplace Balto, Md.

16 (a) Informant Mrs. Florence L Dilworth
(b) Address 601 Arkeney Rd. City
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/47 (month) (day) (year)
(c) Cemetery or crematory St Francis
Location Abingdon Md.
18 (a) Funeral director L. J. Ryck
(b) Address 5305 Harford Rd.
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-47 19 , at M
21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1947, to 11-7 1947, and that I last saw him alive on 11-7 1947.

Immediate cause of death	Duration
Acute hepatitis	
Due to Cerebral Ulcer	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James McC. Finney M. D.
Address Union Memorial Hosp Date signed 11-7-47

Huntington Williams, M.D.

X

656744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 656744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1822 N. Mount St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 N. Mount St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret E. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Samuel Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 1875

8. AGE: Years 72 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry L. Boyer

13. Birthplace Md.

MOTHER 14. Maiden Name Mary E. Johnson

15. Birthplace Md.

16 (a) Informant Samuel Williams

(b) Address 1822 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/47 (month) (day) (year)

(c) Cemetery or crematory Balto Nat

Location Md

18 (a) Funeral director George F. Kelly

(b) Address 1303 Presstman St

19 (a) (Name signed by) (Official capacity) (b) [illegible] Md.

VS [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1947 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10, 1947 to Nov. 6 1947. and that I last saw h[illegible] alive on Nov. 5, 1947.

Immediate cause of death Carcinoma Uterus — Duration 7 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. F. Kelly M. D.
Address 1516 Mount St. Date signed 11-8-47.

X

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. Be especially important. Be sure to give correct age in years.

G56745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G56745
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace SC (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Jane Hilliard
15. Birthplace SC

16 (a) Informant Lewis Brown
(b) Address 1215 E Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co md

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1947, at 3:15 PM

21. I certify that I took charge of the remains described above, held an Inq + Aut (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uterine-sclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl E Ryder M.D. (Medical Examiner)
Date signed 11-7-47

G56746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56746 Registered No. 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Rural - Essex Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 52 Shipway 54
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara E. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Luther Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1876

8. AGE: Years	Months	Days	If less than one day
71	9	27	hr. min.

9. Birthplace Brooklyn, New York
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Koebler
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret
15. Birthplace Ireland

16 (a) Informant Mrs. Hubert E. Carpenter
(b) Address 52 Shipway, Dundalk

17 (a) Burial (b) Date thereof Nov. 10, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Road

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) Huntington Hillmans M.H.
(Signature of registrar)
(b) Date received NOV 9 1947

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6 1947 at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sabinski M.D.
Medical Examiner.
Date signed 11/6/47

656747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

656747

Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8210 Dundalk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor B. Barnwell ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: John Barnwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-7-1895

8. AGE: Years 52 | Months 2 | Days 1 | If less than one day ____hr. ____min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Burtles
13. Birthplace Delaware

MOTHER
14. Maiden Name Ella Harrington
15. Birthplace Delaware

16 (a) Informant John Barnwell
(b) Address

17 (a) Burial (b) Date thereof Nov. 10, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bayside Chapel
Location Frederica, Delaware

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) 1947 (b) [illegible] Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8-47 19..., at 8:43 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1947 to 11-8 1947, and that I last saw h[illegible] alive on 11-8 1947.

Immediate cause of death	Duration
Pulmonary embolism	
Due to Thrombosis, left femoral	
Due to Disease	
Other Conditions Pulmonary tuberculosis, minimal, F.A. not determined	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. G. Chowlber M.D.
Address The Union Memorial Hospital Date signed 11/8/47

950

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G56748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G56748 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 Jeffrey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 - Jeffrey St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Gumm.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Clarence W. Gumm
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 4-1888
8. AGE: Years 59 | Months 8 | Days 4 | If less than one day ____hr. ____min.
9. Birthplace: West Va. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: W. Hoover
13. Birthplace: West Va

MOTHER
14. Maiden Name: M. Kerr
15. Birthplace: West Va

16 (a) Informant: Carl H. Gumm
(b) Address 20 Jeffrey St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 11-47 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Cemetery
Location: West Va.
18 (a) Funeral director: Milton Schilling
(b) Address 3914 Hanover St
(c) Date rec'd by registrar NOV 9 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1947, at 9.30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1947 to Nov 8 1947 and that I last saw her alive on Nov 8 1947.

Immediate cause of death: Toxemia

	Duration
Due to: Eclampsia of the Fetus	
Due to: Retention of Dead Fetus	
Other Conditions: Anemia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Samuel Rubin M. D.
Address 2036 Eutaw Place Date signed

VS 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

BC# 3-9145
G56749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √159

G56749 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the cause to which death should be charged statistically. Underline the cause of which age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: S. Balto. Gen. Hosp. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 7 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 S. Bagley St 24 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Baby Girl Clark

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1947

8. AGE: Years	Months	Days	If less than one day
			7 hr. min.

9. Birthplace Baltimore City Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Emory Clark
13. Birthplace Md.

MOTHER
14. Maiden Name Dorothy Swingler
15. Birthplace Md.

16 (a) Informant Dorothy Clark
(b) Address 901 S. Bagley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Bel Ritchie Highway
18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7, 1947, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1947, to 11-7 1947, and that I last saw h alive on 11-7 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Atelectasis	7 hrs
Due to Prematurity (28 wks)	7 hrs
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William L. Keller M. D.
Address S. Balto Gen Hosp Date signed 11-8-47

VS 150

G56750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G56750 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3510 Old York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Old York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIE J. MORRIS

3 (b) If veteran, name war: -----
3 (c) Social Security Account No. -----

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alonzo D. Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 61 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Richard J. Mooney
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Grady
15. Birthplace Ireland

16 (a) Informant Mr. Alonzo Morris
(b) Address 3510 Old York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) [illegible] (Filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6/47 19 ..., at 5:00 M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/25 1947 to 11/6 1947 and that I last saw her alive on 11/5 1947.

	Duration
Immediate cause of death Coronary occlusion	
Due to Coronary disease	6 yrs.
Due to —	
Other Conditions Diabetes mellitus	6 mos.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. W. Grayston
Address 3963 Greenmount Ave Date signed 11/8/47 M.D.

VS 150

94a

G56751 BALTIMORE CITY HEALTH DEPARTMENT G56751
CERTIFICATE OF DEATH 194a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Fugan
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-20-0442

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Elberta Fugan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25th, 1886

8. AGE: Years	Months	Days	If less than one day
61	7	13	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business Quiet May Oil Burner

MOTHER / FATHER
12. Name
13. Birthplace
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. John A. Fugan
(b) Address
17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/11/47 (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location Chase, Md.
18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Rd.
19 (a) 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 1947, at 3:20 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on 11/8 1947.

Immediate cause of death	Duration
Pulmonary edema	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Coronary sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed 11/8/47

Nov 9

VS 150 Huntington Williams, M.D.

X

Please use CAUSES OF DEATH and age is especially important. Physicians: please write the

656752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 656752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 Fawn St.
(c) Hospital or institution: 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Fawn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cemelia Popoli

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Laurence Popoli
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3. [redacted]

8. AGE: Years	Months	Days	If less than one day: hr.	min.
73.	-	2	18	24

9. Birthplace Italy (Town, county, state or foreign country)
10. Usual Occupation Home. Wife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mrs. Mary Fitzpatrick
(b) Address 2912 Gilford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 5. 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Wendel Bryant
(b) Address 316 N. Highland Ave

[redacted] 1947 (Date received by Registrar) (b) Funeraltown Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1947 to Nov. 5 1947, and that I last saw h[redacted] alive on Nov 5 1947.

Duration
24 hrs.
?
11 mos
4 mos

Immediate cause of death: Acute Cardiac Failure
Due to Chronic Endocarditis Myocarditis
Cerebral Apoplexy
Due to Arterial Sclerosis
Other Conditions Cardiac Asthma

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death [redacted] due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Douglas
Address 2007 E Pratt St Date signed 11/9/47

correct age is especially important. Physician: please write the

VS 150

656753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 656753

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 Huntington Ave.
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Huntington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Wesley Keller.-

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-8212.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Florence M. Keller.- 6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 14, 1880

8. AGE: Years 67 | Months 5 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Freight Conductor

11. Industry or business Penna. R.R.-

FATHER
12. Name Joseph Keller.-
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Barbara Smith
15. Birthplace Carroll Co. Md.-

16 (a) Informant Mrs. Florence M. Keller.-
(b) Address 2109 Huntington Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem.
Location Freeland, Balto. Co., Md.

18 (a) Funeral director Jacob Hartenstein
(b) Address New Freedom, Pa.

19 (a) NOV 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1947 at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Nov 8 1947, and that I last saw him alive on Nov 7 1947.

Immediate cause of death	Duration
Coronary Thrombosis	Immediate
Due to Chr. Arteriosclerosis	
Several years	
Due to	
Other Conditions Myocarditis Chronic, Inf. & Decompensation.	Inf

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M. Beck M. D.

Address 1005 - 23 rd st Date signed Nov 9

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

056754 B.C. D.13649 BALTIMORE CITY HEALTH DEPARTMENT 1159 Registered No. 056754

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto (If outside city or town limits, write RURAL and give town) East
(d) Street No. apt. 227 Essex (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Crapster

3 (b) If veteran, name war no | 3 (c) Social Security Account No. none

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-8-47

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Mortimer Crapster
13. Birthplace Maryland

MOTHER 14. Maiden Name Viola Crapster
15. Birthplace Texas

16 (a) Informant Mother
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-47 (month) (day) (year)
(c) Cemetery or crematory Family Burial Ground
Location Florence Miss

18 (a) Funeral director J.C. Higinbothom
(b) Address Ellicott City Md

19 (Date rec'd by registrar) NOV 10 1947 (Signature of registrar) Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9 1947 at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1947 to 11-9 1947 and that I last saw h/er alive on 11-9 1947

Immediate cause of death: Congenital Atelectasis — Duration: 1 Day

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy 11-9-47

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Williams D. Earley
Address Mercy Hosp Date signed 11-9-47

VS 150

*Please write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

056755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 056755

PLEASE WRITE PLAINLY with unfading ink. Use no abbreviations. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) All ye

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 11
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 Parkdale
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy B. (Kowalewski) Kowalewski

3 (b) If veteran, name war /
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife M. J. (Kowalewski)
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 11-12-(18)98

8. AGE: Years	Months	Days	If less than one day
60 (43)	11	(28)	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation H W
11. Industry or business

FATHER
12. Name Vincent Razzkowski
13. Birthplace Lithuania

MOTHER
14. Maiden Name Grace
15. Birthplace Lithuania

16 (a) Informant M. J. (Kowalewski)
(b) Address 3606 Parkdale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10 47 (month) (day) (year)
(c) Cemetery or crematory Franklin Cem
Location Pa.

18 (a) Funeral director Joseph Kaunakas
(b) Address 60 E Washington Blvd

19 NOV 10 1947 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8 1947 at 6 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1947 to 11-8 1947. and that I last saw him alive on 11-8 1947.

Immediate cause of death Coronary Hemorrhage — Duration 8 hrs

Due to HCVD — 10 yrs

Due to Diabetes — 10 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Huntington Williams M.D.
Address Mercy Date signed 11-9-47

VS 150

656756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 656756

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4739 Alhambra Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4739 Alhambra Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Moody

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-12-9898

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1914

8. AGE: Years 33 | Months 1 | Days 15 | If less than one day hr. 25 min.

9. Birthplace Montreal Canada (Town, county, and state)

10. Usual Occupation Mimeograph Operator

11. Industry or business Montgomery Wards

FATHER
12. Name Charles Noble
13. Birthplace Bolton Lancs, England

MOTHER
14. Maiden Name Rebecca Hobbler
15. Birthplace England

16 (a) Informant Rebecca Marshall
(b) Address 4739 Alhambra Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md

18 (a) Funeral director Wilson & Dorsey
(b) Address 1219 E Cold St

19 NOV 10 1947 (Date received by local registrar) (b) Huntington for Williams Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1947, 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15/47 to 11/7 1947, and that I last saw her alive on 11/2 1947.

	Duration
Immediate cause of death: Hemorrhage (vaginal)	2 hours
Due to: Pelvic Carcinoma (Carcinoma of Cervix)	8 months
Due to:	
Other Conditions: Cachexia (Include pregnancy within 3 months of death)	5 months

Date of operation 4/1/46

Major findings of operation: Uterine curettage showed evidence of Carcinoma

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony J Thomas

Address 4600 York Rd Date signed 11/8/47 M.D.

Correct age is especially important. Physicians, please write plainly.

VS 150

56757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G56757

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3018 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN MARIE HOLLJES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1880

8. AGE: Years	Months	Days	If less than one day
66	9	24	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation School teacher, retired
11. Industry or business

FATHER
12. Name Diedrich Holljes
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNA BULTMANN
15. Birthplace GERMANY

16 (a) Informant Mary E. Holljes
(b) Address

17 (a) Burial (b) Date thereof 11-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road
18 (a) Funeral director Wm. Cook, Inc.
(b) Address 121 E. Paul St.
19 (a) (b) Huntington Williams, M.D.
Registrar

NOV rec'd by registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1947 at 4 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1947 to Nov. 9 1947 and that I last saw h[er] alive on Nov. 9 1947.

Immediate cause of death Toxemia Cardiac Failure
Due to Carcinoma of Uterus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Carcinoma of uterus grade II
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Henry W. D. Holljes M. D.
Address 2839 Woodbrook Ave. Date signed 11-9-47

X

656758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. 656758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 Trenton Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Trenton Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Diehl

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-2265

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19 1889

8. AGE: Years 58 Months 1 Days 18 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business

FATHER
12. Name John Diehl
13. Birthplace Germany

MOTHER
14. Maiden Name Katie Gompfer
15. Birthplace Germany

16 (a) Informant Mrs Emma Diehl
(b) Address 2208 Trenton Place

17 (a) Burial (b) Date thereof 11/11/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto.
Location " Md

18 (a) Funeral director Huntington Williams
(b) Address 1217 E Coal

19 (a) NOV 10 1947 (b) Huntington Williams, Md
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 28 May 1946 to 7 Nov 1947, and that I last saw h[illegible] alive on 7 Nov 1947.

Immediate cause of death	Duration
Myocardial failure	1 month
Due to Coronary Atherosclerosis	
Due to CHF	18 months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard Snodgrass M.D.
Address 1213 N. Milton Ave Date signed 5 Nov 47

correct age is especially important. Physicians: please write plainly.

VS 130

56759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No. G56759

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4916 Litchfield Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4916 Litchfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgie Caroline Hause

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles Kendall Hause
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) September 21, 1892

8. AGE: Years	Months	Days	If less than one day
55	1	17	hr. min.

9. Birthplace Hampstead, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Food Fair

FATHER
12. Name George Sharrer
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Hurly
15. Birthplace Carroll County, Md.

16 (a) Informant Mrs. Charles K. Hause
(b) Address 4916 Litchfield Ave.

17 (a) Burial (b) Date thereof Nov. 10, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director J. Miller Lansdale
(b) Address 4510 Liberty Heights Ave.

19 (a) NOV 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1947, at 12.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23, 1947 to Nov. 8, 1947, and that I last saw her alive on Oct. 26 1947.

Immediate cause of death	Duration
Carcinoma	
Recto-vaginal wall	
Extending into uterine cervix	
Due to And Broad ligaments	6 months or more prior to death
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice E. Shamer M. D.
Address 3300 W. North Ave. Date signed 11/8/47

correct age is especially important. Physicians: please write clearly and legibly.

VS 150

56780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 656780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 Homewood Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co.
(c) City or town Glen Burnie Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 A St. Glen Burnie
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Jeanette Medora Stinchcomb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Walter M. Stinchcomb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 - 1875

8. AGE: Years	Months	Days	If less than one day
72	5 + 19		hr. min.

9. Birthplace Anne Arundel Co. Md.
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Waring
13. Birthplace Md.

MOTHER
14. Maiden Name Victoria Arnold
15. Birthplace Md.

16 (a) Informant Victor E. Stinchcomb
(b) Address 110 A St. Glen Burnie Md.

17 (a) Burial (b) Date thereof 11/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Asbury Chr. Cem.
Location Annapolis Md.

18 (a) Funeral director E. Wallis Lamoreau
(b) Address 1005 W. Baltimore St.

19 (a) NOV 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1947, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1947, to Nov 9 1947.
And that I last saw her alive on Nov. 9 1947

Immediate cause of death Coronary Occlusion — Duration 5 days
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Harry Hyde M.D.
Address 1100 E North Ave Date signed 11/9/47

VS 150

correct age is especially important. Physicians: please write

56761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. C56761

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Keswick Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 Keswick Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marguerite E. Allison.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife Charles L. Allison.
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov 12, 1891

8. AGE: Years	Months	Days	If less than one day
55	11	25	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Walter B. Maynard.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ellen R. Brosnahan.
15. Birthplace Maryland.

16 (a) Informant Charles L. Allison.
(b) Address 4613 Keswick Road.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Nov 10/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge.
Location Pikesville.

18 (a) Funeral director Cheneweth & Donovan.
(b) Address 3615 17 Chestnut Ave.

19 (a) NOV 10 1947 (Date rec'd by registrar) (b) Huntington Williams, MD

MEDICAL CERTIFICATION P.

20. DATE OF DEATH November 7, 1947, at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to Nov 1 1947, and that I last saw h.. alive on Nov 1 1947

Immediate cause of death	Duration
Cerebral Hemorrhage.	2 hours
Due to Arteriosclerosis	10 yrs.
Due to Diabetes	20 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Arthur G. Davies M. D.
Address 800 N 33rd St Date signed 11-8-47

VS 150

Use black or dark ink and write clearly and legibly. Physicians: please write the correct age is especially important.

056762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 056762

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2432 Lakeview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2432 Lakeview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry M. Weinberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Simon
13. Birthplace Poland

MOTHER
14. Maiden Name Esther
15. Birthplace Poland

16 (a) Informant Minnie Weinberg
(b) Address 2432 Lakeview Ave

17 (a) Burial (b) Date thereof 11-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Washington Blvd
Location Washington Blvd

18 (a) Funeral director Jos. Lewis Inc
(b) Address 2400 Eutaw Place

19 (a) NOV 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8- 1947 at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1947 to Nov. 8 1947 and that I last saw h[illegible] alive on Nov. 5 1947

Immediate cause of death: Acute cardiac failure — Duration: Hour/46

Due to: Coronary thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Steele M. D.
Address 3614 W. North Ave Date signed Nov 8/47

V S 150

Especially important. Physicians: please write

056763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 056763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Woodhaven Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Cummings) Sarah

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Home Work

11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Musa
15. Birthplace Russia

16 (a) Informant Asst. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-47 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Balto Md.

18 (a) Funeral director Jack Levin Inc
(b) Address 2109 Eutaw Pl.

19 [redacted] (by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1947, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1947 to 11/9 1947 and that I last saw her alive on 11/9 1947.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	
Due to HYPERTENSION	
Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	
Other Conditions DIABETES (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold Lusman M.D.
Address Sinai Hospital Date signed 11/9/47

VS 150

937

correct age is especially important. Physicians: please write

56764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 56764

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 766 W. Mulberry st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 766 W. Mulberry st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena Fields

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/?/1902

8. AGE: Years	Months	Days	If less than one day
45	8	?	hr. min.

9. Birthplace Fredrick, Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland.

16 (a) Informant Wm. Fields
(b) Address 203 W. 123rd St. N.Y.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-47 (month) (day) (year)
(c) Cemetery or crematory Olivet
Location Frederick Maryland

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

19 (a) NOV 10 1947 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1947 at 8 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1947 to 11-6 1947, and that I last saw h[illegible] alive on Nov. 6 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 2 hrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature
Address Date signed 11/7/47 M.D.

correct age is especially important. Physicians: please write the

VS 150

56765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G56765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 S.Bouldin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 S.Bouldin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Reimers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.6, 1874

8. AGE: Years	Months	Days	If less than one day
73		1	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Lohn
13. Birthplace Germany

MOTHER
14. Maiden Name Koenig
15. Birthplace Germany

16 (a) Informant Henry F.Reimers
(b) Address 2549 W.Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/47 (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway.

19 NOV 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1947 at 7 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Nov 7 1947 and that I last saw h alive on Nov 7 1947

Immediate cause of death	Duration
Lymphosarcoma of Stomach	1-3-45
Due to Coronary Thrombosis	7-12-47
Acute Coronary Occlusion	11-6-47
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Aschenbrenner M. D.
Address 842 S Ext Ave Date signed 11-9-47

correct age is especially important. Physicians: please write the

VS 150

G56766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

Registered No. G56766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 S. Highland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 S. Highland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Reckenberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna J. Rimmar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1869

8. AGE: Years	Months	Days	If less than one day
77	11	22	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George J.
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Meyer
15. Birthplace Germany

16 (a) Informant Wife
(b) Address 1314 S. Highland Ave.

17 (a) Burial (b) Date thereof 11/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) NOV 10 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6th 1947, at 10 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1947 to Nov 6 1947, and that I last saw him alive on Nov 6 1947.

	Duration
Immediate cause of death Acute Cardiac dilatation	
Due to Grippe cold	2 wks ago.
Due to Arterio Sclerosis & Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. V. Clift M.D.
M. D.
Address 5010 Greenleaf Road Date signed 11-8-47

VS 150

correct age is especially important. Physicians: please write the

556767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 556767

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2904 Brighton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Brighton St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Forney

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 212-16-3935

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna C. Forney
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) May 20, 1871

8. AGE: Years 76 | Months 5 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Phillip Forney
13. Birthplace Phil. Pa.

MOTHER
14. Maiden Name Margaret Hayes
15. Birthplace Baltimore Md.

16 (a) Informant Anna C. Forney
(b) Address 2904 Brighton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) NOV 10 1947 (Registrar's signature) Registrar

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to Nov 8 1947 and that I last saw him alive on Oct 25 1947.

Immediate cause of death	Duration
Coronary occlusion	1 day
Due to: Arteriosclerosis	2 yrs
Due to: Senility	
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Bulla M. D.
Address 576 Park Ave Date signed Nov 9 47

VS 180

Sorgel

56768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 56768

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Spence St.
(If rural give location)
(e) Citizen of foreign country? Nor (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Sorgel

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-873

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1880

8. AGE: Years 67 | Months 8 | Days 20 | If less than one day 6 hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business —

FATHER
12. Name Chris Sorgel
13. Birthplace Poland

MOTHER
14. Maiden Name Caroline Brooks
15. Birthplace Germany

16 (a) Informant Otto Sorgel
(b) Address 1709 Spence St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd

18 (a) Funeral director Edward Foulds
(b) Address 2359 Nash Blvd

19 (a) NOV 10 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1947 to Nov. 8 1947, and that I last saw h[illegible] alive on Nov. 7 1947

Immediate cause of death	Duration
Acute Cardiac Failure	7 ?
Due to Myocardial Degeneration	6 mos
Due to Coronary Infarction	6 mos
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Li Cuis M. D.
Address Mercy Hosp Date signed 11-9-47

PLEASE WRITE PLAINLY. Fill in all blanks. Be sure and write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

VS 150

6769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

Registered No. 056769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St
(c) Hospital or institution: Md. General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Bone
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Greece

3 (a) FULL NAME GUS J. MAGULAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife Pauline Magulas
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 8/15/89

8. AGE: Years	Months	Days	If less than one day
58	2	22	..... hr. ..... min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Storekeeper
11. Industry or business Restaurant

FATHER
12. Name PAULINE CORONEUS JAMES MAGULAS
13. Birthplace GREECE

MOTHER
14. Maiden Name PAULINE CORONEOS
15. Birthplace GREECE

16 (a) Informant Wife Pauline magulas
(b) Address 2801 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10/47 (month) (day) (year)
(c) Cemetery or crematory GREEK ORTHODOX
Location EVANGELISMOS

18 (a) Funeral director Geo. J. Agnew Funeral Home
(b) Address 18 N. Mt. Royal Ave

19 (a) NOV 10 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/1947, at 1 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7 1947, to 11/7 1947, and that I last saw h[illegible] alive on 11/7 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertensive cardiovascular disease	
Due to	
Other Conditions acute left ht failure and pulmonary edema	

(Include pregnancy within 3 months of death)
Date of operation 11/6 47
Major findings of operation Left indirect inguinal hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul G. Herold
Address Maryland Gen Hosp Date signed 11/7/47 M. D.

correct age is especially important. Physicians: please write out

VS 190

656770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 82

Registered No. 656770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Jenkins Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Charles
(c) City or town Newport
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Maude Mattingly

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-21-1869

8. AGE: Years	Months	Days	If less than one day
78	9	20	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER 12. Name John E Ware
13. Birthplace Md.

MOTHER 14. Maiden Name Mildred Adams
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof Nov 10 1947 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt. Olivet, Wash D.C.
Location Washington

18 (a) Funeral director J. W. McLaughlin
(b) Address 2004 4th St N.E. Washington

19 (a) (Date signed by registrar) (b) Washington Co. Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1947 6:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/ 1947 to 11/10 1947.
and that I last saw h[illegible] alive on 10/10 1947

Immediate cause of death	Duration
Coronary failure	
Bronchopneumonia	
ascending Paralysis	
Due to (Ludwig Type)	
Due to	
Other Conditions Syphilis	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature D. W. Mintzer M. D.
Address [illegible] Date signed 11/10/47

VS 150

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

56771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 056771

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 E Eager St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 E Eager St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Howard Price

3 (b) If veteran, name war	3 (c) Social Security Account No.
Wrld War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col.	Married

6 (b) Name of husband or wife Carrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30 1889

8. AGE: Years	Months	Days	If less than one day
58	7	9	hr. min.

9. Birthplace Hanover County Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Isreal Price
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Adams
15. Birthplace Va.

16 (a) Informant Carrie Price
(b) Address 2007 E Eager St

17 (a) Removal (b) Date thereof Nov 11 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Ashland Va

18 (a) Funeral director Mrs. E. C. Elliott, Daughter
(b) Address 1129 N Caroline St

19 NOV 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1947 at 12.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1947 to 11/8 1947 and that I last saw h.i.m alive on 11/7 1947.

Immediate cause of death: Carcinoma - squamous-cell rt lung — Duration: 7 mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation Aug 47
Major findings of operation as above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Rayner Browne
Address 1500 E Madison St Date signed 11/9/47

Rayner Browne x

correct age is especially important. Physicians: please write the

VS 150

56772 JL 28300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 56772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tilly Dix

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
54 ?			hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name ? Tiggle Savage
13. Birthplace ? Va

MOTHER
14. Maiden Name ? Mary Stewart
15. Birthplace ? Va

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (Signature of City Registrar) NOV 10 1947 Registrar for Baltimore City

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1937 to Nov. 7 1947, and that I last saw h. or alive on Nov. 7 1947

Immediate cause of death: Cerebral Thrombosis, old with recent extension — Duration: 10 yrs 1 day

Due to: Hypertension & Cardiovascular Disease, Arteriosclerosis — 4 yrs.

Due to: Heart Disease " Genl. & Cerebral Arteriosclerosis — 4 yrs.

Other Conditions: Arteriolar Nephrosclerosis, aggravated uremi

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 11-7-47

correct age is especially important. Physicians: please write plainly.

V S 190

937

G56773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56773

1. PLACE OF DEATH: D.O.A.
(a) Baltimore City, Maryland
(b) Street address 211 E. Preston St
(c) Hospital or institution:
9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen H. Colliflower ~~Mary Rotheflower~~

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Isaac E. Colliflower
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1877

8. AGE: Years	Months	Days	If less than one day
70	3	21	hr. min.

9. Birthplace La Plata Md (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Geo Howard
13. Birthplace England

MOTHER
14. Maiden Name Dont Know
15. Birthplace Dont

16 (a) Informant Howard E. Colliflower
(b) Address 5710 Harford Rd

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Nov 12 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) NOV 10 1947 (local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1947, at 11:25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiac Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Paul Leibrecht M.D.
Medical Examiner.
Date signed 11/9/47

VS 151

656774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 656774

PLEASE WRITE PLAINLY with pen or pencil, and do not use abbreviations. In order to make a permanent record, it is necessary that the information called for below be full and correct. Be sure and write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 504 N. Robinson St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Martin Ford

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John Ford 51
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1900

8. AGE: Years	Months	Days	If less than one day
47	5	6	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Philip Cross
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Hanlein
15. Birthplace Baltimore

16 (a) Informant Doris Mae Ford.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/47 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2021 Orleans St.

19 (a) NOV 10 1947 (Date rec'd by registrar) (b) Huntington Hollander, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1947, at 2:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1947 to 11/9 1947 and that I last saw h.. alive on 11/9 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	9 hr.
Due to Hypertension - malignant	19 yrs.
Due to Eclampsia not pregnant	less than 24 hrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry V. Chase M. D.
Address Mercy Hospital Date signed 11/9/47

X

56775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 56775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3529 Claremont St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3529 Claremont
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar R. Hurley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Grace Hurley
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) April 12, 1892

8. AGE; Years	Months	Days	If less than one day
55	6	24	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Ship Fitter.
11. Industry or business

FATHER
12. Name Arthur T. Hurley
13. Birthplace Md

MOTHER
14. Maiden Name Clara Thompson
15. Birthplace Md

16 (a) Informant Grace Hurley
(b) Address 3529 Claremont St

17 (a) Burial (b) Date thereof Nov 10th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem
Location City

18 (a) Funeral director Welsch Funeral Home
(b) Address 2205 Orleans St

19 NOV 10 1947 (c) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6th 1947, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5, 1947, to Nov. 6 1947, and that I last saw h-- alive on Nov. 6, 1947.

Immediate cause of death	Duration
Coronary Thrombosis	day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Constantine M.D.
Address 2?? S Caroline St Date signed 11-8-47

VS 150

correct age is especially important. Physicians: please write clearly.

G56776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G56776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2625 Hollins Ferry Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2625 Hollins Ferry Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Irene Kinsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Albert S. Kinsey deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June-17-1861

8. AGE: Years 86 | Months 3 | Days 21 | If less than one day 22 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Edward Stalling
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret E. Seymour
15. Birthplace Baltimore.

16 (a) Informant Wm George Reynolds
(b) Address 2625 Hollins Ferry Rd

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 12-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Fernand C. Hayle
(b) Address 121 E West St

19 (a) NOV 10 1947 (Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November-9-1947 at 1 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Nov. 9-1947 and that I last saw h alive on Nov-8-1947.

Immediate cause of death	Duration
Cancer of the breast with lung-metastases	about 12 years.
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter H. Sonnenfeldt M.D.
Address 2708 Hollins Ferry Rd Date signed 11/9/47

VS 150

Please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

556777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 556777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Paul & 23rd
(c) Hospital or institution: Dr Bucks Stone

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603-W-40-Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Fredrick Dussman

3 (b) If veteran, name war none | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Laura G. Dussman | 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 25 1865

8. AGE: Years 82 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Mechanical Engr

FATHER
12. Name Henry Dussman
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Bleker
15. Birthplace Germany

16 (a) Informant Mr Henry C. Dussman Son
(b) Address 4503 Thompkett Ave (Ut)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-10-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Sylvester Myers Co.
(b) Address 108 W Mt Royal Ave.

Date Nov 8 1947 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1947 at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1947 to Nov 7 1947 and that I last saw h[illegible] alive on Nov 6 1947.

Immediate cause of death Cardiac Failure — Duration 2 hrs

Due to Pneumonia — 10 hrs

Due to Emphysema — 3 yrs

Other Conditions Chronic Nephritis — 10 yrs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry C Dussman M. D.
Address 1006 23rd St. Date signed 11-7-47

VS 150

113

FOR BOARD OF HEALTH USE ONLY. Physicians; please write the causes of death clearly and legibly. correct age is especially important.

56778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. 56778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2113 E. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Basto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 E Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine King

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Basto (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Weingold
13. Birthplace Germany

MOTHER
14. Maiden Name Maria K. Dennerstein
15. Birthplace Germany

16 (a) Informant George King (Son)
(b) Address 2113 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 10 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Mark Fr. E. Degidis
(b) Address 37 S. Carrollton Ave.

19 NOV 10 1947 Huntington Williams M.D. Registrar
(Date accepted by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1947, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 st 1947 to 11/6 th 1947, and that I last saw h[illegible] alive on 11/6 th 1947.

Immediate cause of death	Duration
Cardiac Failure	3 Days
Due to Cardio Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Gunter M. D.
Address 100 N Mulberry Date signed 11/9/47

correct age is especially important. Physicians: please write clearly and legibly.

VS 150

056779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. 056779

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

656780 BALTIMORE CITY HEALTH DEPARTMENT 656780
CERTIFICATE OF DEATH 30E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital DOA

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1422 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Blake

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex M | 5 Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Minnie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/1905

8. AGE: Years	Months	Days	If less than one day
42 41	2	24	hr. min.

9. Birthplace N. C
(Town, county and state)
10. Usual Occupation Chauffeur
11. Industry or business
FATHER 12. Name Henry Blake
13. Birthplace N. C
MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Minnie Blake
(b) Address 1422 Madison Ave
17 (a) Burial (b) Date thereof 11/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Gladonia N. C
Location N. C. Gastonia
18 (a) Funeral director Geo. G. Kelagon
(b) Address 1303 Prestman St
NOV 10 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Nov 8 1947 at 11:10 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Syphilitic Cardio-Vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William A Holfeld M.D.
Medical Examiner.
Date signed Nov 9, 1947

VS 151

G56781 — BALTIMORE CITY HEALTH DEPARTMENT — G56781

CERTIFICATE OF DEATH 47

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2036 Eastlund ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2032 E Eastland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Horacek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1874

8. AGE: Years	Months	Days	If less than one day
73	4	17	hr. min.

9. Birthplace Czecho-Slavakia (Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business

FATHER
12. Name Joseph Horacek
13. Birthplace Czecho-Slavakia

MOTHER
14. Maiden Name Barbara Rozlovsky
15. Birthplace Czecho-Slavakia

16 (a) Informant Joseph Horacek
(b) Address 2036 Eastlund ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10/47 (month) (day) (year)

(c) Cemetery or crematory Oak Hill
Location Baltimore Md

18 (a) Funeral director Frank Brockden
(b) Address 900 E. Chester St

19 (a) (registrar) (b) Registrar

V S 150

correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8, 1947, at 6:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 47 to Nov 8 1947, and that I last saw h alive on Nov 5 1947

Immediate cause of death Hypostatic Pneumonia — Duration 11/6/47

Due to Carcinoma of Lung — Aug 1 1947

Due to Carcinoma of Urinary Bladder — Aug 1 1947

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William F. Brauer M.D.

Address 801 4 Cleveland Ave Date signed 11/9/47

X

G56782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56782

Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Riverside Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John Francis Schulz

3 (b) If veteran, name war: None.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Mary Catherine Mahoney
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Jan 7 1882

8. AGE: Years	Months	Days	If less than one day
65	11	1	hr. min.

9. Birthplace Baltimore Maryland. (Town, county, and state)
10. Usual Occupation Retired policeman
11. Industry or business

FATHER
12. Name Ferdinand Schulz
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Smith
15. Birthplace Baltimore Md.

16 (a) Informant Daughter
(b) Address 1003 Riverside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-1947 (month) (day) (year)
(c) Cemetery Holy Cross
Location Ritchie Highway A.A.Co

18 (a) Funeral director Elizabeth Hall Inc.
(b) Address 115 E. 31st St.
(c) 10 1947 Harrington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8/47 1947, at 12:17 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7 1947, to 11/8 1947, and that I last saw him alive on 11/8 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive Cardio vascular disease and Coronary	over 3 yrs over 7 yrs.
Due to Heart Disease	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry V. Chase M. D.
Address Mercy Hospital Date signed 11/8/47

VS 150

656783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

656783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 851 Abbott Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 851 Abbott Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Lockard

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Widowed

6 (b) Name of husband or wife Walter J. Lockard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29. 1871

8. AGE: Years	Months	Days	If less than one day
75	11	9	hr. min.

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation House worker
11. Industry or business at Home

FATHER
12. Name John Burlinson
13. Birthplace England

MOTHER
14. Maiden Name Mary Ann O'Connor
15. Birthplace Ireland

16 (a) Informant Mr. Joseph W. Lockard
(b) Address 851 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11/47 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cem
Location 4300 Old Frederick Rd

18 (d) Funeral director Edgar W. Coughlin Sons
(e) Address 934 E. Fayette St

19 (a) 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/1947, at 11:9 M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1947 to 11/7/1947 and that I last saw h[illegible] alive on 11/7/1947.

Immediate cause of death [illegible] Cardiac Insufficiency Chronic Nephritis

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Lockard M. D.
Address 1422 Park Ave Date signed 11/7/47

VS 150

Write the cause of death clearly and legibly. Physicians: please write correctly. Age is especially important.

G56784 G56784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 Hull St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIOLA OWSIK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Zygmont
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-19-1889

8. AGE: Years 57 | Months 10 | Days 12, 19 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Johan Makolski
13. Birthplace Poland

MOTHER 14. Maiden Name Mary Bartczak
15. Birthplace Poland

16 (a) Informant Helen Kolodziejski
(b) Address 1512 Plum St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 200 Liberty Heights Ave
NOV 10 1947 (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/47 19 , at 3:55 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 11/7/47

G56785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G56785 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4305 Parkmont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4305 Parkmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie R. Vogt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Louis E. Vogt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29, 1887

8. AGE: Years 60 | Months 2 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Centreville Md
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Thomas D. Thawley
13. Birthplace Md

MOTHER
14. Maiden Name Mary Turner
15. Birthplace Md

16 (a) Informant Arthur F. Vogt
(b) Address 4305 Parkmont Ave

17 (a) Burial (b) Date thereof Nov. 11 - 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Mrs. Wm. John H. Teufel-Son
(b) Address 5311 Edmondson Ave

19 (a) ... (b) ...
Date received ... Registrar ...

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7th 1947, at 4.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Nov 7 1947, and that I last saw h[illegible] alive on Nov 7, 1947

Immediate cause of death Myocardial failure

Due to arteriosclerosis with hypertension

Due to ...

Other Conditions ...

(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operations: ...
... of autopsy: ...

Duration between onset and death
... years
...
...
...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ...
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature Dr. J. Babbage M. D.
Address 5829 Belair Rd Date signed 11/10/47

correct age is especially important. Physicians: please write

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56786

G56786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Relay (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. Sheridan

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 705-05-2511

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Erma Ray Sheridan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1903

8. AGE: Years 44 | Months 4 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Chase, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B. & O. Railroad

FATHER
12. Name John Klonza Sheridan
13. Birthplace Md.

MOTHER
14. Maiden Name Victoria O. Hayden
15. Birthplace Md.

16 (a) Informant Mrs. Erma I. Sheridan
(b) Address 1709 Arlington Ave., Relay

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 15

NOV 10 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1947, at 1:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1947 to 11-8 1947 and that I last saw h[im] alive on 11-8 1947

Immediate cause of death	Duration
Intraventricular hemorrhage	
Due to Hypertension (?).	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Intraventricular hem

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. B. Mayne M. D.
Address Univ. Hosp. Date signed 11-8-47

X

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G56787

43526 d

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V137a

G56787 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore B
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2716 N. Calvert
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country.....

3 (a) FULL NAME James Franklin Harris

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-1640

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	W.

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/72

8. AGE: Years	Months	Days	If less than one day
74	10	13	....hr. ....min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation retired police
11. Industry or business

FATHER
12. Name John Harris
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia Seamans
15. Birthplace Del

16 (a) Informant Mrs. Annie Smith
(b) Address 2716 N. Calvert St.

17 (a) Burial (b) Date thereof 11/10.47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 10 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 8 - 1947 19..., at 325 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1947, to 11/8 1947, and that I last saw him alive on 11/8 1947.

Immediate cause of death	Duration
Cerebro vascular accident	
Due to 11 hrs following perineal prostatectomy	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-7-47

Major findings of operation: Benign Prostatic Hypertrophy.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Clarence V. Hodges M. D.
Address Johns Hopkins Hosp. Date signed 11/8/47

correct age is especially important. Physicians: please write

VS 150

G56788 G56788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1526 W. Fairmont ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 W. Fairmont ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Annie Fields Jenkins

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Walter Jenkins
6 (c) If alive, give age: 47 years
7. Birth date of deceased (mo., day, yr.): Feb. 4, 1900
8. AGE: Years: 47 Months: 9 Days: 2 If less than one day: — hr. — min.
9. Birthplace: Brunswick Co, Virginia (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business:

FATHER
12. Name: John Fields
13. Birthplace: Brunswick Co, Va

MOTHER
14. Maiden Name: Charlotte Hicks
15. Birthplace: Brunswick Co., Va

16 (a) Informant: Walter Jenkins
(b) Address: 1526 W. Fairmont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 10, 1947 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location:

18 (a) Funeral director: Mrs. Katy R. Wilh[illegible]
(b) Address: 322 N. Schroeder St

[illegible] (b) [illegible] Burlington Williams, Registrar

correct age is especially important. Registrar.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11. 6. 47 19 2:20 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9.18.47 19 to 11.6.47 19, and that I last saw h&r alive on 11.5.47 19

Immediate cause of death: Uremia — Duration: 3 days
Due to: Cardiorenal vascular Disease — 9.18.47
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Major findings: Of operations: Massive Fibroma uteri - November 1946 - Union Hospital
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: James M. Fair M. D.
Address: 40 W Caroll[illegible] Date signed: 11-6-47

A-C
G567897 38918

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

74 B

G56789 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Co.
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Avenal Rd
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Hesse

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-45

8. AGE: Years	Months	Days	If less than one day
1	10 22	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Richard Hesse
13. Birthplace Md.

MOTHER
14. Maiden Name Irene Wood
15. Birthplace Md.

16 (a) Informant Parents
(b) Address 4 Avenal Rd. Essex

17 (a) Burial (b) Date thereof Nov. 12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Bengies Mill Rd.

18 (a) Funeral director Thos. J. Connelly
(b) Address 415 Eastern Ave. Essex

19 (a) 11-10-1947 (b)
(Date received by Registrar) Registrar

correct age is especially important. Physician: please write plainly.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9 1947, at 1:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-1947, to 11-9-1947, and that I last saw her alive on 11-8 1947.

Immediate cause of death	Duration
Resp. & cardiac failure	
Due to Leukemia Leukemia	
Due to General debility	
Other Conditions Gangrenous stomatitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Rouse M. D.
Address University Hosp. Balto 1, Md. Date signed 11-9-47

656790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. 656790

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 Bethel ave.
(c) Hospital or institution: Harwood aged People's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10yr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Bethel ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Katherine Schwalenberg

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Frank H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1865

8. AGE: Years	Months	Days	If less than one day
82	7	15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Heinbecker
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Martin Schwalenberg
(b) Address 503 N. Longwood St.

17 (a) Burial (b) Date thereof 11 - 11 - 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fallsway & Fayette St.

19 (a) Nov 10 1947 by registrar Huntington Williams, MD

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Nov. 7/47 19 , at 1.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1/47 19 to Nov. 7/47. and that I last saw her alive on Nov. 7/47 19

Immediate cause of death	Duration
Chronic Cardiac Hypertrophy	Unknown.
Due to Arterio-Sclerosis	Unknown.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Henry Hanes Slaughter M. D.
Address 920 Stevens Date signed Nov. 10/47

VS 150

x Nov.

056791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. 056791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 N. Fremont Ave D.O.A
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Minor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Mary C. Miner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 - 8 1879

8. AGE: Years	Months	Days	If less than one day
68	2	-	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name John Miner
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Priscilla Sorsell
15. Birthplace Va.

16 (a) Informant Mrs. Mary L. Miner
(b) Address 202 Fremont ave.

17 (a) Burial (b) Date thereof Nov. 12, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. H. Hoffman
(b) Address 1631 Pennsylvania Ave. Huntington Woodlawn, Md.

19 NOV 10 1947 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 1947 at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Seibert M.D.
Medical Examiner.
Date signed 11/9/47

VS 181

792 B.C.# 4-8124

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157M

Registered No. G56792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 North Broadway
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Main Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Carter (Grace)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/6/47

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name William A. Carter
13. Birthplace Connecticut

MOTHER
14. Maiden Name Grace Allen
15. Birthplace Missouri

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo NOV 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 10 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1947, at 4:12PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1947, to Nov. 7 1947, and that I last saw her alive on Nov. 7 1947.

Immediate cause of death	Duration
Multiple congenital anomalies	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. C. Williams M. D.
Address The Johns Hopkins Hospital Date signed 11-7-47

correct age is especially important. Physicians: please write

VS 150

X

Jones

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 233 University Parkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara E. Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Charles Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1879

8. AGE: Years 68 47 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Lutherville, Maryland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name James Sonlick
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant Charles Jones
(b) Address 233 University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director Charles R. Lane
(b) Address 802 Mad. Ave.

19 (Name of informant) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1947, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to Nov. 6 1947 and that I last saw h.[illegible] alive on Nov 6 1947.

Immediate cause of death	Duration
Cachexia	months
Due to Generalized Carcinomatosis	2+ years
Due to Bronchogenic Carcinoma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Generalized Carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. L. Williams M. D.
Address Mercy Date signed 11-7-47

VS 150

656794 B.C.D. 2-9476 BALTIMORE CITY HEALTH DEPARTMENT 656794

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 S Poppleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Minnick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7, 1947

8. AGE: Years | Months | Days | If less than one day: 9 hr. 55 min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER 12. Name John Melvin Minnick
13. Birthplace Washington D.C.

MOTHER 14. Maiden Name Mary Elizabeth Britton
15. Birthplace Balto Md.

16 (a) Informant Mrs Mary Minnick
(b) Address 117 S. Poppleton St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV, 10, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 10 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS-76

correct age is especially important. Physicians: please write legibly. Cause of death must be certified by physician only.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1947, to Nov 7 1947, and that I last saw h.. alive on Nov 7 1947.

Immediate cause of death: Cardio-respiratory failure — Duration

Due to: Prematurity (28 wks)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Shear
Address University Hospital Date signed 11/9/47

G56795 G56795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 B

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 659 W. Fayette St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Frank Bowers (William Frank Bowers)

3 (b) If veteran, name war

3 (c) Social Security Account No. 179-10-7663

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: ~~Divorced~~

6 (b) Name of husband or wife: ~~Iva~~ Bowers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/17/1886

8. AGE: Years	Months	Days	If less than one day
61	1	24	hr. min.

9. Birthplace Mt. Holly Springs Pa (Town, county, and state) Md.

10. Usual Occupation Watchman

11. Industry or business Southern States Corp.

FATHER
12. Name William Bowers
13. Birthplace Mt Holly Springs Pa

MOTHER
14. Maiden Name Katherine Eshbach
15. Birthplace Mt. Holly Springs Pa

16 (a) Informant Mrs. Ida J. Boyd
(b) Address 659 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. W. Lamoreau
(b) Address 1003 W. Baltimore St.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

Remington-Williamson, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1947 at 5:50 A

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 1947 to Nov. 10 1947 and that I last saw h.m alive on Nov. 9 1947.

Immediate cause of death: Uremia — Duration

Due to: Tuberculosis of Kidneys

Due to: Miliary Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Mercy Hospital Date signed 11/10/47

X

056796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 056796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 St. Paul St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cloyd Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
M	W	

6 (b) Name of husband or wife ——

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-4-69

8. AGE: Years	Months	Days	If less than one day
77 78	11	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Mr. Lewis
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Winger
15. Birthplace Maryland

16 (a) Informant Hospital Reports
(b) Address Union Memorial

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12 47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Olivet
Location Frederick - Md.

18 (a) Funeral director C.E. Cline & Son
(b) Address Frederick, Md.

19 (a) Date received by registrar NOV 11 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1947 at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1947 to Nov. 10 1947, and that I last saw him alive on 10 Nov. 1947

Immediate cause of death	Duration
Cerebral thrombosis	10 Days
Due to Hardening of arteries	many
Due to	
Other Conditions Arteriosclerotic Heart Disease	many

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] M. D.
Date signed 11-12-47

83B

G56797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56797 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 74 N. Monastery Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 74 N. Monastery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert R. Harrison, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Minnie M. Harrison nee Grebe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1888

8. AGE: Years 59 | Months 2 | Days 13 | If less than one day ___ hr. ___ min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Patrolman

11. Industry or business Baltimore City Police Dept.

FATHER
12. Name Jackson Harrison
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Carrie Colleen
15. Birthplace Md.

16 (a) Informant Mrs. Minnie Harrison
(b) Address 74 N. Monastery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Whittle.
(b) Address 4101 Edmondson Ave.

19 (a) 1947 (b) [illegible] Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8/47. 1947, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1945 to Nov 8 1947, and that I last saw h. alive on Oct 25 1947.

Immediate cause of death: Coronary Thrombosis — Duration 1 hr

Due to: Hypertensive Arteriosclerotic Heart Disease — Duration 4 yrs

Due to: — Duration

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1 1/7/47 Date signed

X

correct age is especially important. Physicians: please write

656798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

656798 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 239 E. Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 w
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 239 E. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (~~Yes~~ No)
If yes, name country

3 (a) FULL NAME Marius Asch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Elizabeth Asch

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) July 25th 1887

8. AGE: Years 60 | Months 3 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Dish Laundry

FATHER
12. Name Carl Asch
13. Birthplace Germany

MOTHER
14. Maiden Name Helen Rabein
15. Birthplace N. Y. City N. Y.

16 (a) Informant Mrs. Elizabeth Asch
(b) Address 239 E. Lafayette Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/12/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Maryland Park
Location Parkville Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 1947, at 10 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1947 to 10-8 1947 and that I last saw him alive on 10-8 1947

Immediate cause of death	Duration
Coronary Occlusion	5 hrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Flynn M.D.
M. D.
Address 11 E. Chase St Date signed Nov 10 1947

VS 153

X

G56799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56799 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2120 Barclay st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Whitter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Crafton Whitter

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 26th 1876

8. AGE: Years	Months	Days	If less than one day
70	11	13	hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: John Gunther
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Mary "
15. Birthplace: "

16 (a) Informant: Mrs. Lena Somers
(b) Address: 3311 Dupont Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/12/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Mt. Olivet
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul st.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 9th 1947, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to Nov 9 1947, and that I last saw h[illegible] alive on 11-7-47 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 2-5 years

Due to: Hypertension cardio vascular renal disease, and arteriosclerosis

Due to: Grippe

Other Conditions: —
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: R. Carey M.D.
Address: 642 Nash Bld. Date signed: 11-10-47 M. D.

VS 150

X

G56800 ✓ G56800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2503 Barclay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2503 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** La Fevre A. Foige

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elsie H. Foige

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) June 7, 1879

8. AGE: Years 68 | Months 5 | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Plumber - Retired

11. Industry or business

FATHER
12. Name Henry Foige
13. Birthplace France

MOTHER
14. Maiden Name Josephine Wright
15. Birthplace Harford County, Md.

16 (a) Informant Beatrice Foige
(b) Address 2503 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1947 to 11/8 1947, and that I last saw h alive on 19

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Arteriosclerotic Cardio-Vascular Disease — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum

Address 1206 E. Curtis St. Date signed M. 11 D. 10/47

X

correct age is especially important. Typewrite or print plainly.

VS 150

656801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

Registered No. 656801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Wentworth Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew C. Dotterweich

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: Katherine Oates

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Jan. 8, 1890

8. AGE: Years	Months	Days	If less than one day
57	10	2	hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Jacob Dotterweich
13. Birthplace: Bavaria

MOTHER
14. Maiden Name: Mary Speigel
15. Birthplace: Balto., Md.

16 (a) Informant: Records
(b) Address: U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/47 (month) (day) (year)
(c) Cemetery or crematory: U. S. National
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1947, at 2:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27 1947 to Nov. 10, 1947, and that I last saw him alive on Nov. 10, 1947.

Immediate cause of death: Carcinoma of epiglottis with extension to base of tongue and cervical Secondary lymph nodes.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

Duration
6 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: A. L. Koven M. D.
Address U.S.M. Hospital Date signed 11/10/47

correct age is especially important. Physicians: please write distinctly.

V S 190

656802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1336

656802 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Main ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anita Sneider

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7, 1932

8. AGE: Years 15 | Months 9 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Morris Sneider
13. Birthplace Africa

MOTHER
14. Maiden Name Sarah Flachsman
15. Birthplace Balto. Md

16 (a) Informant Morris Sneider
(b) Address 4200 Maine ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11/47 (month) (day) (year)
(c) Cemetery or crematory Beth Jibon Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 Fayette St

19 (a) 11 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1947 at 5 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1947 to 11-10 1947 and that I last saw h[illegible] alive on 11-10 1947

Immediate cause of death: anemia — Duration
Due to: renal insufficiency
Due to: Unknown Cause
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliott L. Weissman M. D.
Address Sinai Hosp Date Nov 10-47

Correct age is especially important. Physician: please write plainly.

VS 150

G56803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G56803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: SINAI Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Santa Fe Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Zetlin

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-09-9923

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lottie Zetlin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation operator

11. Industry or business pants factory

FATHER 12. Name Harry Zetlin

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah ?

15. Birthplace Russia

16 (a) Informant Lottie Zetlin

(b) Address 2818 Sante Fe Ave

17 (a) Burial (b) Date thereof Nov, 11, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Rosedale Cem

Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) Date received by reg. Huntington Williams, M.D. Registrar

NOV 12 1947

VS 150

Correct age is especially important. Physicians: please write clearly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 NOV. 1947, at 8.22 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 25 OCT. 1947, to 10 NOV. 1947, and that I last saw him alive on 10 NOV. 1947

Immediate cause of death	Duration
Generalized Carcinomatosis	
Due to Site unknown	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 30 OCT 47

Major findings of operation: Epitheliol Orchiectomy

of autopsy Generalized carcinomatosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Irving Schatzki

Address Sinai Hospital Date signed 10 Nov 47

Beta. X

G56804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 169 — G56804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Ferndale (If outside city or town limits, write RURAL and give town)
(d) Street No. Glenburnie (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME David (Stevan) Hebron

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace A. A. Co., Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Robert Hebron
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Henson
15. Birthplace Md.

16 (a) Informant John Hebron (Bro.)
(b) Address Ferndale, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director James A. Hayes
(b) Address 142 Westfield Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1947, at 6.25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy/Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock due to traumatic amputation of both legs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-8-47 at 8 P.M.
(b) Where did injury occur? Ferndale Station
(c) Did injury occur at home, on farm, industrial place, in public place? R.R. Station While at work? no
(d) Means of injury Pedestrian struck by train

23. Signature [illegible] M.D. (Medical Examiner.)
Date signed 11-10-47

VS 151

G56805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56805 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3618 Gibbons Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 Gibbons Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph A. Warnecka

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-10-9637

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Lillian E. Warnecka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1893

8. AGE: Years 54 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Railroad Engineer

11. Industry or business Beth. Steel Co.

FATHER 12. Name Albert F. Warnecka

FATHER 13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Isabel White

MOTHER 15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Lillian E. Warnecka

16 (b) Address 3618 Gibbons ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 11 47 (month) (day) (year)

17 (c) Cemetery or crematory Parkwood Cemetery

Location Taylor Ave

18 (a) Funeral director Howard N. Bligh Jr.

18 (b) Address 6009 Harford Road

19 (a) (Date rec'd by registrar) (b) [illegible]

NOV 11 1947

correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1947, at 5-10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to Nov. 8, 1947 and that I last saw him alive on 11/8 1947

Immediate cause of death: Hypertensive Cardio-Vascular Disease — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Janney

Address 7101 Harford Rd. Date signed M 11 D. 10 /47

X

B.C.# 2-81815

G56805

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

G56806 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1835 McHenry St.
(c) Hospital or institution:
19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1835 McHenry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Wayne Sparrow

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 20, 1947

8. AGE: Years | Months: 4 | Days: 21/2 | If less than one day: 0 hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: None
11. Industry or business: None

FATHER
12. Name: Henry C. Sparrow
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Irma Wolbert
15. Birthplace: Maryland

16 (a) Informant: Henry C. Sparrow
(b) Address 1835 Mc Henry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director: George L. Schwab
(b) Address 2101 Frederick ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williamson, M.D. (Registrar)

NOV 11 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1947, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1947 to Nov. 10 1947, and that I last saw him alive on Nov. 10 1947

Immediate cause of death	Duration
Congenital Heart Disease	4 months 21 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred Cole M. D.
Address 1934 Wilkens Ave Date signed 11-10-47

X

Write the cause of death correctly and legibly. Physicians: please correct age is especially important.

656807
J1 - 115105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

✓ 656807
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Whittington

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Patricia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1905

8. AGE: Years	Months	Days	If less than one day
42	0	2	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Counterman
11. Industry or business Playland 4th & Balto St.

FATHER
12. Name Charlie
13. Birthplace N. C.

MOTHER
14. Maiden Name Julia
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Pratt St.

(a) 11 1947 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1947, at 10.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1947 to Nov. 8 1947, and that I last saw him alive on Nov. 8, 1947

Immediate cause of death Poisoning from drinking denatured ?
Due to
Due to
Other Conditions Alcohol intoxication
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Toxic gastritis + Cystitis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. T. Benfard M. D.
Address Balt. City Hosp. Date signed 11-10-47

To be approved by Medical Examiner
John R. Davis, M.D. Per:

V S 150

correct age is especially important. Physicians: print write the

G56808 BALTIMORE CITY HEALTH DEPARTMENT ✓ G56808
CERTIFICATE OF DEATH 46F Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 Pitcher St.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Pitcher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Addie L. Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. Charles J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1869

8. AGE: Years 78 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Charleston, S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Winfield Scott
13. Birthplace Charleston, S.C.

MOTHER 14. Maiden Name Elizabeth ?
15. Birthplace South Carolina

16 (a) Informant Mrs. Everett Lane
(b) Address 1607 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Lee H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b)

NOV 11 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1947 at 4:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1947 to Nov 7 1947 and that I last saw h alive on Nov 7 1947.

Immediate cause of death: Carcinoma of Liver — Duration: 6 mo

Due to:

Due to:

Other Conditions: Metastasis 2 to Ovarian

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury
23. Signature J. H. Rostaphes M.D.
Address 825 N. Fremont Ave. Date signed 11/11/47

correct age is especially important. Physicians: please write plainly.

X

G56809 BALTIMORE CITY HEALTH DEPARTMENT G56809 Registered No. 3648

CERTIFICATE OF DEATH 51B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 Strieker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Over 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Strieker
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. H. Gross

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Mary Gross
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-10-1869

8. AGE: Years	Months	Days	If less than one day
78	—	28	— hr. — min.

9. Birthplace Calvert Co Md
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business none now

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Hester Gross
15. Birthplace

16 (a) Informant Susie Wilson
(b) Address 1105 Strieker St.

17 (a) Burial (b) Date thereof 11/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Coopers Chapel
Location Calvert Co Md

18 (a) Funeral director George B. Nelson
(b) Address 803 Presstman St.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8-1947 at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1-1947 to 11-8-1947 and that I last saw h— alive on 11-7-1947.

Immediate cause of death	Duration
Carcinoma of Prostate	Unknown
Due to Unknown	
Due to	
Other Conditions Myocarditis, hypertension and arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M.D.
Address 1029 N Strieker St. Date signed 11-8-47

correct age is especially important. Physicians, please

VS-150

X

G56810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G56810 Registered No. 830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECREASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2437 Old Frederick Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Volkert

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife ^
6 (c) If alive, give age ^ years

7. Birth date of deceased (mo., day, yr.) Dec. 3-1871

8. AGE: Years	Months	Days	If less than one day
75	9 11	5	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name J. J. August Volkert
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Germany

16 (a) Informant Mrs. Victor Lattener
(b) Address 239 S. Hilton St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 11/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. R. Wippert. Son
(b) Address 1300 Eutaw Place

19 (a) (b) Registrar

NOV 11 1947

VS 150

Huntington Williams, M.D.

1948 - Block Street.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1947, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1947, to Nov. 8 1947, and that I last saw her alive on Nov 8 1947.

Immediate cause of death: Cerebral Thrombosis of Cerebral Vessels — Duration —
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stella McDonald M. D.
Address 1948 - Block Street. Date signed 11/9/47

correct age is especially important. Physicians: please write plainly.

G56811

BALTIMORE CITY HEALTH DEPARTMENT ✓ G56811

CERTIFICATE OF DEATH 170c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Wagelessa
(If outside city or town limits, write RURAL and give town)
(d) Street No. 447 Angelessa Street.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARTIN (BARALSKI) Boracki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ---------- Boracki
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mr. Michael Goodman
(b) Address 447 Anglesea Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 NOV 11 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1947 at 2:35p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism,
Broncho-pneumonia

Due to

Other Conditions Fracture left femur, middle third.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following: 26/7
(a) Date of injury 10-6-47 at 9.45 a. M.
(b) Where did injury occur? Ponca & Eastern Ave. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by truck

23. Signature Emil H Kruger M.D.
Medical Examiner
Date signed 11-10-47

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X

G56812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G56812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2207 Penrose Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) NO

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 Penrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William G. Derrenberger

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	213-28-9486

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Edna D. Hiskey
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) June 14, 1897

8. AGE: Years	Months	Days	If less than one day
50	4	24	____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Ice Business
11. Industry or business Retired

FATHER
12. Name John Paul Derrenberger
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lena Schmidt
15. Birthplace Baltimore

16 (a) Informant Mrs Edna D. Derrenberger
(b) Address 2207 Penrose Ave.

17 (a) Burial (b) Date thereof 11/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Frederick A. Dyer
(b) Address 200 W. Lombard St.

19 (a) ____ (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V 11 1947

correct age is especially important. Physician: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1947, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1947 to 11/8 1947 and that I last saw him alive on 11/8 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Renal Vascular Disease	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature DeWitt Langdale M.D.
Address 400 N. Payson St. Date signed 11/9/47

X

656813 3, C# 7-9717 BALTIMORE CITY HEALTH DEPARTMENT 656813
CERTIFICATE OF DEATH 157E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 22 1/2 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Deurti

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1947

8. AGE: Years	Months	Days	If less than one day
			22 hr. 30 min.

9. Birthplace Baltimore Baltimore Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Dominic Deurti
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Gorgolo
15. Birthplace Baltimore, Maryland

16 (a) Informant Dominic Deurti
(b) Address 3812 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-47 (month) (day) (year)
(c) Cemetery ~~crematory~~ Sacred Heart
Location German Hill Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St

19 (a) Date rec'd 1947 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1947 to Nov. 11 1947, and that I last saw him alive on Nov. 10 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Congenital Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Burkhart, M.D.
Address Md. Grad Hosp. Date signed 11/11/47

correct age is especially important. Physicians: please write

VS 190

X

056814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

056814 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: Greene & Lombard Sts. Balto.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 N. Ellwood Avenue (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Sylvester Cornell

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-8267

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Emma Cornell (nee Bussmen)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/3/1905

8. AGE: Years 42 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Bethlehem Steel

FATHER
12. Name Walter Cornell
13. Birthplace Sweden

MOTHER
14. Maiden Name Mary Malone
15. Birthplace Baltimore, Md.

16 (a) Informant Emma Bussmen Cornell - wife
(b) Address 106 N. Ellwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) (Date rec'd by Registrar) (b)

NOV 12

VS 190

correct age is especially important. Physician: please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9/47, 1947, at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1947 to 11/9 1947 and that I last saw him alive on 11/9/47

Immediate cause of death	Duration
Coronary failure	
pulmonary edema	
Due to illness	
Due to peritonitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward E. Hall M. D.
Address University Hosp. Date signed 9/11/47

X

G56815 BALTIMORE CITY HEALTH DEPARTMENT G56815

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2438 E. Eager Street
(c) Hospital or institution:
7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2438 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK VANIK

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Frances (nee Kurdna)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1869

8. AGE: Years	Months	Days	If less than one day
78	3	25	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER: 12. Name Frank Vanik
13. Birthplace Czechoslovakia

MOTHER: 14. Maiden Name unknown
15. Birthplace w

16 (a) Informant Helen Vanik
(b) Address 2438 E. Eager Street

17 (a) Burial (b) Date thereof 11/12/1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or [illegible] Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) [illegible] (b)
(Date received) (Registrar)

VS 150

correct age is especially important. Physician: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8/1947 at 8:[illegible] M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1947 to 11/8 1947 and that I last saw h[illegible] alive on 11/8 1947.

Immediate cause of death: Bronchial Pulmonary Edema — Duration 12 hrs
Due to: Chronic Myocarditis — Duration [illegible]
Due to: Hypertension — Duration [illegible]
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address [illegible] Date signed 11/[illegible]/47

656816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

656816

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 W. Camden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Dodd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/23/08

8. AGE: Years	Months	Days	If less than one day
39	11	15	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Dodd
13. Birthplace S. C.

MOTHER
14. Maiden Name Simpson
15. Birthplace

16 (a) Informant Margaret Jones
(b) Address 202 W Camden St

17 (a) Removal (b) Date thereof 11/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Charlotte
Location N. C

18 (a) Funeral director Isaac L Brown & Sons
(b) Address 106 N Fremont Ave Baltimore Md

NOV 12 1947 (Date rec'd by registrar) (By Huntington Williams) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1947 at 11 55 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Royer M.D.
Medical Examiner.

Date signed 11-10-47

G56817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1935

G56817
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Race Track
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Connecticut or County
(c) City or town New Haven
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 Day Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GILBERT DOURLAND

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace N. Y.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name James Dourland
13. Birthplace N. Y.

MOTHER
14. Maiden Name Hattie Jones
15. Birthplace N. Y.

16 (a) Informant Donald Dorsey
(b) Address 3407 Falls Rd

17 (a) Burial (b) Date thereof Nov 12 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Joseph L Bowers
(b) Address 108 W Monument St

19 (a) 1947 Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/47 19 8:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 11/8/47

VS 151

G56818

LW 115048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

115c

G56818 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. # 1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Ezella Bogier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1- 1941

8. AGE: Years	Months	Days	If less than one day
6	10	6	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Bogier
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura
15. Birthplace Maryland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Nov 12, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Stanley ave

19 (a) (b)
(Signature of person who rec'd by registrar) Registrar

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1947, at 10:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6- 1947 to Nov. 7 1947, and that I last saw her alive on Nov. 7 1947

Immediate cause of death	Duration
Anesthesia (Ether)	30 min
Due to None known	
Due to	
Other Conditions None known	

T & A- Operation
(Include pregnancy within 3 months of death)
Date of operation 11/7/47
Major findings of operation: Positive
T & A
of autopsy: Status Lymphaticus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature Carleton C. Douglass M.D.
Address Balto. City Hosp. Date signed 11/7/47

except age is especially important. Physician: please write the

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(Registered No.) 1318 (55819)

55819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st and Wyman Park Drive
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) just arrived

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Talbot
(c) City or town Avalon (If outside city or town limits, write RURAL and give town)
(d) Street No. none given (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George, James Newton

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fay George
6 (c) If alive, give age 19 years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1917

8. AGE: Years 30 | Months 9 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Avalon, Maryland (Town, county, and state)
10. Usual Occupation Merchant Seaman
11. Industry or business 1st Mate

FATHER
12. Name C. Newton George
13. Birthplace Tillman's Island, Maryland

MOTHER
14. Maiden Name Rose Waldron
15. Birthplace St. Michael's Maryland

16 (a) Informant patient
(b) Address above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13/47 (month) (day) (year)
(c) Cemetery or crematory Church Cemetery
Location Talbot Co. Md. Island

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1 Geo. Center Place

19 (a) [illegible] 1947 (b) [illegible] Williams, M.D.
(Signature of local registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1947, 10.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1947, to Nov. 10 1947, and that I last saw h.im alive on Nov. 10 1947.

Immediate cause of death	Duration
Uremia due to Chronic Glomerular Nephritis	3 months
Due to	
Due to	
Other Conditions Fibrinous Pericarditis	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fenwick S. Moore Jr. M. D.
Address U.S. Marine Hospital Date signed 11/13/47

Correct age is especially important. Physicians: please write clearly

656820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No. 656820

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th Street
(c) Hospital or institution:
Home for Incurables. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th ST
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Daniels Uhler.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (d) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Philip R Uhler.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1859

8. AGE: Years 88 | Months - | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore md -
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name William B. Daniels
13. Birthplace Virginia

MOTHER
14. Maiden Name Julia Ann Dutton
15. Birthplace Baltimore Md -

16 (a) Informant Home for Incurables Records
(b) Address 700 W. 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12, 47 (month) (day) (year)

(c) Cemetery or crematory London Park
Location 3801 Fredericke Ave.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1410 Eutaw Place

19 (a) ____ (Date received by registrar) Huntington Williams, M.D. Registrar

NOV 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1947, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26th 1939, to Nov. 10th 1947, and that I last saw her alive on Nov. 10 1947.

Immediate cause of death	Duration
Progressive Intestinal Obstruction	2 months
Malignant and Ulcerative Lymphosarcoma	8 years
Due to	
Other Conditions Hypertrophic arthritis	10 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Carmack Wolf M. D.
Address 11 E. Chase St. Baltimore 2 Maryland Date signed 11/10/47

correct age is especially important. Registrar, please

X

656821 | BALTIMORE CITY HEALTH DEPARTMENT | 656821

CERTIFICATE OF DEATH 96

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Green St
(c) Hospital or Institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 17
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County:
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 No Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME Mary Dann

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Bernard D.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1857

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace: Newyork NY (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Abraham Isquith
13. Birthplace: Russia

MOTHER
14. Maiden Name: Pearl
15. Birthplace: Russia

16 (a) Informant: Bernard Dann
(b) Address: 1212 N Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-12-47 (month) (day) (year)
(c) Cemetery or crematory: Beth Tfiloh
Location: Dundalk Mill Road

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 760 Eutaw Place

NOV 11 1947 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

correct age is especially important. Physicians: please write out

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10-1947, at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1947 to 11-10 1947, and that I last saw h[illegible] alive on 11-10 1947.

Immediate cause of death	Duration
[redacted] Coronary failure	
Due to massive cerebral hemorrhage; probably arteriosclerotic def	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: C B Kearns M. D.
Address: Univ Hosp Date signed: 11-10-47

X

G56822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G56822 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2413 E Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2413 E Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Goldscher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years: 73 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name: Israel
13. Birthplace: Poland

MOTHER
14. Maiden Name: Sarah
15. Birthplace: Poland

16 (a) Informant: Anna Goldscher
(b) Address: 2413 E Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-47 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Mt Carmel
Location:

18 (a) Funeral director: Jack Levin Inc
(b) Address: 2106 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 5 1950 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1- 1947 at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1947 to Nov 5 1947 and that I last saw h[illegible] alive on Nov 5 1947

Immediate cause of death: Coronary Thrombosis — Duration: 6 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: B M Bergquist
Address: 3455 Pk Hghts Date signed 11/11/47

correct age is especially important. Physicians: please write plainly.

Huntington Williams, Registrar

X

656823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

656823 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 E 32nd. Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 E. 32nd. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN C. HAMMERBACHER

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Annie Ruth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1862

8. AGE: Years 85 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Real Estate

FATHER
12. Name Leonard Hammerbacher
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth meiser
15. Birthplace Germany

16 (a) Informant Mrs. F.Edward Schneider
(b) Address 1931 E. 32nd. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date received) (Registrar's signature) Registrar

NOV 11 1947
V S 150

correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION P

20. DATE OF DEATH November 8 1947, at 9.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943 to Nov 8 1947 and that I last saw him alive on Nov 8 1947

Immediate cause of death: Chronic myocarditis — Duration: 15 years
Due to Arteriosclerosis
Due to Pyelonephritis Bilat complete Hernia
Other Conditions Urine retention Uremia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. V. Harbold M. D.
Address 4706 Harford Road Date signed 11-10-47

G56824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G56824 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913- Eutaw Place.
(c) Hospital or institution: Twilight Nursing Home 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 Harlem Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD S. GODWIN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-03-1847

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1878

8. AGE: Years 69 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ?

11. Industry or business FEDERAL TIN Co.

FATHER
12. Name John W. Godwin
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara M. Forsyth
15. Birthplace Maryland

16 (a) Informant Mrs. S.E. Baldwin - sister
(b) Address Havre de Gras, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/47 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

NOV 11 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1947, at 10 a. M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage, Spontaneous.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard S. Mueller M.D. Medical Examiner.
Date signed 11-10-47

656825 BALTIMORE CITY HEALTH DEPARTMENT 656825
CERTIFICATE OF DEATH 1316 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1914 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN R. DELANEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Clara A. Delaney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1863

8. AGE: Years	Months	Days	If less than one day
84	4	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Policeman
11. Industry or business Balto. City

FATHER
12. Name James H. Delaney
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah -
15. Birthplace Ireland

16 (a) Informant Mr. Joseph E. Delaney
(b) Address 2804 Auchentoroly Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1947, at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Nov 8 1947. and that I last saw him alive on Nov 11 1947

Immediate cause of death	Duration
Acute cardiac dilatation	1 day
Due to Chronic myocarditis	2yrs
Due to chronic nephritis	2yrs
Other Conditions -	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Coles
Address 4 N. Fulton Date signed 11/13/47 M. D.

correct age is especially important. Physicians: please write the causes of death clearly, and fill in all blanks.

VS 150

X

656826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

656826 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hollen Busey Hoffman Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Cornelia D. Hoffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1905

8. AGE: Years	Months	Days	If less than one day
42	2	19	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Harry Hoffman
13. Birthplace Maryland

MOTHER
14. Maiden Name Mendel Rock
15. Birthplace Maryland

16 (a) Informant Mrs. Cornelia D. Hoffman wife
(b) Address Owings Mills, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1947, at 4:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1947 to Nov 9 1947 and that I last saw ~~him~~ alive on Nov 9 1947.

Immediate cause of death	Duration
Acute Peritonitis	
a Appendicitis	
Due to Postoperative Complications	
Due to	
Other Conditions Hepato-renal insufficiency	

(Include pregnancy within 3 months of death)

Date of operation Oct 23 1947

Major findings of operations Cholecystitis & Cholelithiasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Geo Young Jr. M.D.
Address Univ. Hosp Date signed 11/9/47

correct age is especially important. Physicians: please write

VS 150

656827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

656827 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution:
Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Orem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARA REBECCA WALTEMEYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Orrin Webster Waltemeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
about 75			hr. min.

9. Birthplace Baltimore Co
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Caleb Staines
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Rachael Cross
15. Birthplace Balto. Co., Md.

16 (a) Informant Mr. Orrin Webster Waltemeyer
(b) Address 2211 Orem Ave.

17 (a) Burial (b) Date thereof 11/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 11 1947 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1947, at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29/47 19 , to 11/8/47 19 ; that I last saw her alive on 11/7/47 19

Immediate cause of death	Duration
Uremia	8 days
Due to Chr. Cardio-vascular disease	long
Due to	
Other Conditions Apoplexy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 1901 Eutaw Place Date signed 11/10/47

X

Please write correct age is especially important. Physicians:

6828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

Registered No. 656828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pimlico Race Course
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New York County
(c) City or town Montgomery
(If outside city or town limits, write RURAL and give town)
(d) Street No. 99 Union Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Morris Bartholomew

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Widower

6 (b) Name of husband or wife Late Mary A. Bartholomew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1865

8. AGE: Years	Months	Days	If less than one day
82	6	21	hr. min.

9. Birthplace Phila. Pa. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John J. Bartholomew
13. Birthplace Pa.

MOTHER
14. Maiden Name Emma Engel
15. Birthplace Pa.

16 (a) Informant Rodney T. Bonsall
(b) Address 1335 Land Title Bldg. Phila. Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 11/47. (month) (day) (year)
(c) Cemetery or crematory Riverside Cemetery
Location Montgomery, N. Y.

18 (a) Funeral director Harry H. Whittle
(b) Address 4101 Edmondson Ave.

19 NOV 12 1947 (Date filed by Registrar) (b) [illegible] Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10/47. 19 , at 1.57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1947, to — 19 , and that I last saw h alive on 11/10 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1/2 hour
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. J. Volenick M. D.
Address 4710 Liberty Hts. Date signed 11/10/47

For E. J. Volenick
Howard L. Malkus, M.D.

correct age is especially important. Physicians: please write

5829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 656829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2246 Wilkens Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2246 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Frederick A. Rausch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella R. Rausch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1887.

8. AGE: 50 Years | Months | 6 Days | If less than one day ... hr. ... min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Elevator Operator

11. Industry or business: St. Agnes' Hospital

FATHER
12. Name: Frederick A. Rausch
13. Birthplace: Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Md.

16 (a) Informant: Mrs. Ella R. Rausch
(b) Address: 2246 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12/47 (month) (day) (year)
(c) Cemetery or crematory: Meadow Ridge Memorial Pk.
Location: Dorsey, Md.

18 (a) Funeral director: Harry A. Deutsche.
(b) Address: 4101 Edmondson Ave.

19 (a) NOV 12 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 9/47. 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Nov 9 1947 and that I last saw him alive on Nov 8 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to: Hypertension	
Due to: Imp. Cerebral Circulation	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Robert C. Hatch M.D.
Address: 2251 Wilkens Av. Date signed: 11/13/47

correct age is especially important. Physicians: please write the

VS 130

X

56830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

656830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 772 Edgewood St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 777 Edgewood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME William Edward Mc Sweeney

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-6869

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Widower

6 (b) Name of husband or wife Late Mary J. McSweeney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1873

8. AGE: Years	Months	Days	If less than one day
73	10	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Baker

11. Industry or business Md. Biscuit Co.

FATHER
12. Name Daniel Mc Sweeney
13. Birthplace Ireland

MOTHER
14. Maiden Name Hannah Carey
15. Birthplace Balto. Md.

16 (a) Informant John J. Mc Sweeney
(b) Address 498 S. Monastery ave

17 (a) Burial (b) Date thereof Nov. 12 /47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Lipsitz
(b) Address 4101 Edmondson Ave.

NOV 12 1947 Huntington Williams Mfr
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1947, at 9:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1947 to Nov 9 1947, and that I last saw h[illegible] alive on Nov 8 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Bronco pneumonia	
Due to	
Other Conditions Arterio-sclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. F. French MD
Address 2329 Arunah Ave Date signed M. 11 D. 9 /47

5831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 65683F

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Co.
(c) City or town Elliott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Meirich Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leonidas Doty
3 (b) If veteran, name war
3 (c) Social Security Account No. 214 03 4747

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife. Mrs. Leonidas Doty (Nannie T. Doty)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 18, 1883.
8. AGE: Years 64 | Months 2 | Days 21 | If less than one day hr. min.
9. Birthplace New York (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Bethlehem Ship Bldg. Co.

FATHER
12. Name William D'Orville Doty
13. Birthplace Massachusetts

MOTHER
14. Maiden Name ? Haskell
15. Birthplace Massachusetts

16 (a) Informant Leonidas Doty
(b) Address 241 Leeds Terrace, Arbutus, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12/47. (month) (day) (year)
(c) Cemetery or crematory Lorraine Pk.
Location Woodlawn, Md.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave.

19 (a) 11 12 1947 Registered by Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9-47 19 , at 6:16 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1947 to 11-9 1947.
and that I last saw h. alive on 11-9 1947.

Immediate cause of death: Carcinoma Liver

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James McL. Feeney M. D.
Address Union Memorial Hosp. Date signed 11-9-47

correct age is especially important. Physicians: please write the

X

56832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G56832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Talbot
(c) City or town Edgemore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Duncan

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: married Duncan
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Nov 18, 1892

8. AGE: Years 54-55 | Months 11 | Days 24 | If less than one day: hr. min.

9. Birthplace Vernonville, Md (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name John Duncan
13. Birthplace Maryland

MOTHER
14. Maiden Name C. Rutledge
15. Birthplace Maryland

16 (a) Informant wife
(b) Address Joppa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 1943 (month) (day) (year)
(c) Cemetery or crematory Vernville
Location Vernville Md

18 (a) Funeral director Wesley Hubbard
(b) Address Miami Shore La

NOV 12 1942 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1942, at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1942, to Nov 12 1942, and that I last saw him alive on Nov 11 1942.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Faranacci M. D.
Address Mercy Hosp. Date signed 11/12/1942

Please write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

56833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 56833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 E. HENRIETTA ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 E. HENRIETTA ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAGDELINE (LENA) HAAS

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) AUG. 1869

8. AGE: Years	Months	Days	If less than one day
78	3		hr. min.

9. Birthplace MARYLAND.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name MARTIN HAAS
13. Birthplace GERMANY

MOTHER
14. Maiden Name LOUISE SCHLARP
15. Birthplace GERMANY

16 (a) Informant MR JOHN HAAS
(b) Address 7 E. HENRIETTA ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 13 47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVE.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 NOV 12 1947 (Date rec'd by registrar) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1947 to Nov 10 1947 and that I last saw h. alive on Nov 10 1947

Immediate cause of death	Duration
Coronary Heart failure	1 day
Due to	
Due to	
Other Conditions Diabetes acidosis (Include pregnancy within 3 months of death)	1 week

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 1125 Eutaw St. Date signed 11/11/47

correct age is especially important. Physicians: please write

VS 150

6834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered C56834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 E. Hamburg St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 E. Hamburg St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest O. Bennett

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-07-2426

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma Breeden

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1904

8. AGE: Years 43 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Paint Co.

FATHER
12. Name William H. Bennett
13. Birthplace Virginia

MOTHER
14. Maiden Name Nilla Darrow
15. Birthplace Virginia

16 (a) Informant Mrs Emma Bennett
(b) Address 9 E. Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)

(c) Cemetery or crematory CEDAR HILL
Location Ritchie Highway

18 (a) Funeral director John F Denny Sue
(b) Address 714 Light St.

19 (a) NOV 12 1947 (Date rec'd by registrar) (b) [illegible] Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1947, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6 1947 to 11/11 1947 and that I last saw h.. alive on 11/6 1947.

Immediate cause of death
Cerebral Edema
Cause Alcoholism?
Due to (Chronic alcoholism
Cirrhosis of liver
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
?
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E J Ellison M. D.
Address 107 E. Way Date signed 11/14/47

correct age is especially important. Physicians: please write

VS 150

56835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. 56835

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 Riverside Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Riverside Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Frederick Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-07-9201

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Shipyard

FATHER
12. Name John Miller
13. Birthplace Md

MOTHER
14. Maiden Name Anna E. Zilch
15. Birthplace Missouri

16 (a) Informant Margaret Burns
(b) Address 1020 Riverside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave

18 (a) Funeral director John F. Denny Jr.
(b) Address 716 Light St.

19 NOV 12 1947 (Date rec'd by registrar) Wellington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1947, at 3:45 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 12 1947 to 11/7 1947. and that I last saw h. alive on 11/7 1947.

Immediate cause of death	Duration
(a) Uremia - Chronic Glomerular Kidney Disease	7
Due to (b) Cirrhosis Liver	?
Due to (c)	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 107 E. West St. Date signed 11/11

correct age is especially important. Physicians: please write clearly and legibly.

56838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1132

Registered No. C56838

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 W. Burnett (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Joseph F Hockler HOCKLER

3 (b) If veteran, name war: 1w

3 (c) Social Security Account No. 214-03-5468

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mary Hockler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 29 1886

8. AGE: Years	Months	Days	If less than one day
61	9	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William J. Hockler
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Son
(b) Address 1167 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13. 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mr. & Mrs. John H. Tenbrunsel
(b) Address 5311 Edmondson Ave

19 NOV 12 1947 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1947, at 8 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1947 to 11/10 1947, and that I last saw him alive on 11/10 1947

Immediate cause of death Pneumonia — Duration Unknown

Due to Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation /
Major findings of operation: /

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Fraser M.D.
Address Mercy Hosp Date signed 11/10/47

VS 150

56837.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G56837. Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town ~~2108~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 St. Paul (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence Carson CARSON JR.

3 (b) If veteran, name war: WWI
3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ida May
6 (c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.) 24-04

8. AGE: Years 43 | Months 9 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Kansas (Town, county, and state)

10. Usual Occupation Retired Army Officer

11. Industry or business

FATHER 12. Name Lawrence Carson
13. Birthplace S. C.

MOTHER 14. Maiden Name Francis Holliday
15. Birthplace Ill

16 (a) Informant Ida M Carson
(b) Address 2108 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/47 (month) (day) (year)
(c) Cemetery or crematory Arlington Nat Cem
Location Ft Myer Va

18 (a) Funeral director Gelhaus & Dye
(b) Address 2104 St Paul St

NOV 12 1947 (Date rec'd by registrar) Huntington Williams M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1947, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1947 to Nov. 10 1947 and that I last saw him alive on Nov. 10 1947.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	
Due to ARTERIAL HYPERTENSION	4 YRS.
Due to	
Other Conditions CARDIAC ENLARGEMENT ARTERIO SCLEROSIS	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy: Above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Freeman D Stephens M. D.
Address Johns Hopkins Hosp Date signed 11 11 47

correct age is especially important. Physicians: please write plainly, using ink.

83a

56838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G56838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Paul and 23rd sts
(c) Hospital ~~or institution~~: Dr. Brooks Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul P. Morphopoulos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband~~ or wife: Marigo Morphopoulos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13th 1873

8. AGE: Years 74 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Hotel Keeper

FATHER
12. Name Panos Morphopoulos
13. Birthplace Greece

MOTHER
14. Maiden Name ? Paras Kevi
15. Birthplace Greece

16 (a) Informant Mrs. Chas. P. Penimore
(b) Address 349 Wilson st. Harwood, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/47
(month) (day) (year)
(c) Cemetery or crematory Greek Community
Location Midland Md

18 (a) Funeral director William Oak Pac.
(b) Address 1217 St. Paul St.

19 NOV 12 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9th 1947 at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Nov 10 1947 and that I last saw him alive on Nov 9 1947.

Immediate cause of death	Duration
Coronary Thrombosis	Immediate
Due to Coronary Sclerosis & Arteriosclerosis	Indefinite
Due to Rheumatic Heart	
Other Conditions Chr. Myocarditis & Enlarged Heart (Include pregnancy within 3 months of death)	Indefinite

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Samuel M Beck M. D.
Address 102 E. 22nd St Baltimore Md Date signed Nov 10 47

56839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56839 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 West 26th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 West 26th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Loleta M. Kinnaird

3 (b) If veteran, name war: —
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: Alexander Kinnaird
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 2, 1880

8. AGE: Years	Months	Days	If less than one day
67	5	9	hr. min.

9. Birthplace: Winchester, Virginia (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Lewis
13. Birthplace: Roanoke, Virginia

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Mrs. Alexander Kinnaird
(b) Address: 8 West 26th Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) NOV 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

Correct age is especially important. Physicians, please.

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1947, at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1947 to 11/11 1947 and that I last saw her alive on 11/11 1947.

Immediate cause of death	Duration
Coronary Thrombosis	2 hrs
Due to Myocarditis	Gradual
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: W. H. Brady M.D.
Address: 140 E Park ave Date signed 11/13/47

VS 150

X

56840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1953

Registered No. G56840

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 650 Portland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ona Rackauckas

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	W	married

6 (b) Name of husband or wife Andrew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Matthews Pazaulauskas

13. Birthplace Lith

MOTHER 14. Maiden Name ?

15. Birthplace Lith

16 (a) Informant Andrew Rackauckas

(b) Address 650 Portland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md

18 (a) Funeral director Joseph Casmakes

(b) Address 10 E Washington St

NOV 12 1947 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1947, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1947 to Nov 8 1947, and that I last saw h[illegible] alive on Nov 8 1947

	Duration
Immediate cause of death Pulmonary Edema	1 day
Due to Rheumatic Heart Disease	?
Due to	
Other Conditions Sclerosis of Central nervous system (Include pregnancy within 3 months of death)	5th yrs.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

25. Signature Johns P. Ulrich Jr.

Address 1227 Wash Blvd Date signed M 11/10/47 D

correct age is especially important. Physicians: please write plainly.

VS 150

56841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 13 B

Reg. No. C56841

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Lorman St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Percy Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: Dorothy

6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) 9-18-16

8. AGE: Years 31 | Months 1 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William Anderson
13. Birthplace N. C.

MOTHER 14. Maiden Name Ollie Watkins
15. Birthplace N. C.

16 (a) Informant Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/'47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Arbutus, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1206 Druid Hill Ave.

19 NOV 12 1947 (b) Huntington Williams, M.D.
(Date received by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1947, at 11 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1947 to Nov. 9 1947 and that I last saw him alive on Nov 9 1947.

Immediate cause of death Disseminated Tuberculosis involving lungs, brain, meninges, peritoneum, Bones and Kidneys — Duration

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Sherman M. Mellinkoff M. D.
Address Johns Hopkins Hosp. Date signed 11/10/47

VS 150

correct age is especially important. Physicians: please write plainly.

B.C.# 7-5709

6842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Reg. 056842

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 E Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard J. Ehmsen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21-1946

8. AGE: Years 1 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edwin Ehmsen
13. Birthplace New Jersey

MOTHER 14. Maiden Name Mildred ~~Dotson~~ Davis
15. Birthplace Balto. Md.

16 (a) Informant Edwin Ehmsen
(b) Address 2209 E. Fayette St.

17 (a) Burial (b) Date thereof Nov 12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Eastern Ave.

18 (a) Funeral director John L. Miller
(b) Address 2334 Jefferson St.

19 (a) (b)
Death rec'd by (Registrar) Hamilton for Williams M.D.
NOV 12 1947
VS A 150 . 1A 1A

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 10 - 1947, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept - 21 - 1946 to Date 1947, and that I last saw him alive on Nov - 8 - 1947.

Immediate cause of death Myocardial Meningeal Meningococcal Septicemia — Duration Birth

Due to Acute Mastoiditis

Due to Encephalitis

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature: Wm. V. Geyer M.D.

Address 1 S. M. Mellonville Date signed 11/10/47

correct age is especially important. Physicians: please write clearly and legibly.

56843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G56843 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 Longwood Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Longwood Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ellen Wells

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Wallace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1885

8. AGE: Years 62 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace County Wexford, Ireland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin Quigley
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Unknown
15. Birthplace Ireland

16 (a) Informant Lawrence Fitzhenry
(b) Address 1405 Longwood Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 NOV 12 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

correct age is especially important. Typewrite or print plainly in ink.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1947, at 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1947 to Nov 11 1947 and that I last saw her alive on Nov 10 1947

Immediate cause of death Circulatory failure due to uremia — Duration 1 wk
Due to Carcinoma of [illegible] — 3 mos?
Due to Arteriolar nephrosclerosis — 5 yrs
Other Conditions — ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James O'Brien
Address 5701 York Rd Govans Md Date signed M. D. 11/12/47

X

56844 D.C. 2-78039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Reg. C56844

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4832 Park Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Primrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Parker Higgs Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6th 1947

8. AGE: Years	Months	Days	If less than one day
	6	4	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James P. Higgs Sr.
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Marian Ford
15. Birthplace Somerset Co. Md.

16 (a) Informant James P. Higgs
(b) Address 3908 Primrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/47 (month) (day) (year)

(c) Cemetery or crematory Loraine
Location Woodlawn Md

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul st.

19 NOV 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

Correct age is especially important — Physicians please cooperate

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10th 1947, at 2:45 P.M.

21. I certify that death occurred on the date above stated: that I attended deceased from 5/6 1947, to 11/10 1947, and that I last saw him alive on 11/10 1947.

Immediate cause of death Pneumonia — Duration 2 days

Due to — Duration over

Due to

Other Conditions Maldevelopment Congenital — (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irwyn Muller M.D.
Address 4832 Park Heights Ave Date signed 11/12/47

X

6845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G56845 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2136 E. Oliver St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2136 E Oliver St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter B. Sommerlock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 31st 1889

8. AGE: Years	Months	Days	If less than one day
58	7	9	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Conductor
11. Industry or business W. M. R. Road

FATHER
12. Name John L Sommerlock
13. Birthplace Md

MOTHER
14. Maiden Name Thedorshia Bannokes
15. Birthplace Md

16 (a) Informant Mrs Mary L Sommerlock
(b) Address 2136 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Moelands
Location Taylor Ave

18 (a) Funeral director 1201-03 N. Patterson Park ave
(b) Address Geo G Cook

NOV 12 1947 (Date rec'd by registrar) (b) Washington Hillsboro Md

VS 150

Geo. G. Cook

correct age is especially important. Physicians: please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9th 1947, at 6.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9th 1947 to Nov. 9 1947 and that I last saw h/ alive on Nov. 8 1947.

Immediate cause of death Cancer Lung X — Duration 1½ yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Schneider M. D.
Address 1101 N. Milton Ave Date signed 11-11-47

X

8846 B-Cert A-93665

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

G56846 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Bon Secours Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore-15 Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3109 Acton Road.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Stephen Dennis Hemmeter.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/10/47

8. AGE: Years	Months	Days	If less than one day
1½days.			....hr. ....min.

9. Birthplace Bon Secours Hospital.
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Louis Hemmeter.
13. Birthplace Baltimore, Maryland.

MOTHER
14. Maiden Name Concetta Mary Maggio.
15. Birthplace Baltimore, Maryland.

16 (a) Informant Father.
(b) Address 3109 Acton Road Balto-14Md.

17 (a) Buried (b) Date thereof 11/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Balto

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd

19 (a) NOV 12 1947 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 1947, at 8:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1947 to 11-11 1947 and that I last saw h.im alive on 11-11 1947

Immediate cause of death..... Cerebral Hemorrhage. — Duration.....
Due to.....
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature George W. Fetter M. D.
Address Bon Secours Hospital Date signed 11-14-47

X

Please write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

56847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G56847

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Keene Av.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margie M. Nottle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Harold E. NOTTLE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-26-1920

8. AGE: Years	Months	Days	If less than one day
76	11	14	___ hr. ___ min.

9. Birthplace Iowa
(Town, county and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Carl S. Johnson
13. Birthplace Minn.

MOTHER
14. Maiden Name Victoria B.
15. Birthplace

16 (a) Informant Rev. Carl S. Johnson
(b) Address 2136 Fildale Drive

17 (a) Burial (b) Date thereof 11/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Balto

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) NOV 12 1947 (b) [illegible]
(Date rec'd by registrar) (Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1947 at 6:27 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 19__, to Nov 9 1947, and that I last saw h. C. alive on Nov 9 1947.

Immediate cause of death Diabetes Acidosis — Duration

Due to Diabetes Mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Univ. Hosp. Redwood & Greene Date signed 11/9/47

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

56848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56848 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3112- Chesley Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELBERSON D. GREEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Anna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2-1903

8. AGE: Years	Months	Days	If less than one day
44	0	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Gas & Electric Co.
11. Industry or business

FATHER
12. Name George D. Green
13. Birthplace Warren-Md.

MOTHER
14. Maiden Name Virginia A. Roke
15. Birthplace Warren-Md

16 (a) Informant Mrs Anna Green
(b) Address 3112 Chesley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Baltimore

18 (a) Funeral director L. J. Luck
(b) Address 530 S Mayford Rd.

19 NOV 12 1947 (Date rec'd by registrar) (By) Hamilton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1947, at 8.30 A M

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wadkins M.D.
Medical Examiner.
Date signed 11-10-47

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56849 ✓ 56849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 3a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2806 Overland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Overland Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Anna Paparis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John Paparis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30-1866

8. AGE:

Years	Months	Days	If less than one day
80	11	11 10	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Joseph Condaro

13. Birthplace Italy

MOTHER 14. Maiden Name ✓

15. Birthplace ✓

16 (a) Informant Mrs. Grace Paparis

(b) Address 2806 Overland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Md.

18 (a) Funeral director Leonard J. Lusk

(b) Address 5305 Harford Road

19 NOV 12 1947 (Date rec'd by registrar) (by) Huntington Williams Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1947, at 3 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947, to 11-10 1947, and that I last saw her alive on 11-1-1947

Immediate cause of death: Cerebral Hemorrhage — Duration 1 Month

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. W. Peake M. D.

Address 4508 Harford Rd Date signed 11-10-47

VS 8

X

8850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G56850 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2138 Mt. Royal Terr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2138 Mt. Royal Terr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Work

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife Walter W. Work
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1877

8. AGE: Years	Months	Days	If less than one day
70	9	25	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Rudolph Knapp
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rose Eckstein
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ruth W. Gardner
(b) Address 2138 Mt. Royal Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 12 1947 Date Rec'd by registrar [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/47 19 at 7 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1, 1947 to Nov 10 1947 and that I last saw alive on Oct 16 1947.

Immediate cause of death Chronic Myocarditis — Duration 2 yrs.
Due to Hypertension & Cardiovascular Disease — 20 yrs.
Due to Diabetes
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Lachman M. D.
Address Date signed

Physicians: please write the causes of death clearly and legibly. Information is especially important. correct age

6851

AB- 113424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

G56851 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos-11days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Whitmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse C. Jarrett

3 (b) If veteran, name war	3 (c) Social Security Account No.
nè	215-09-0869

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Louise K. Jarrett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 4-1889

8. AGE: Years	Months	Days	If less than one day
58	2	6	hr. min.

9. Birthplace Maryland (Balto.)
(Town, county, and state)
10. Usual Occupation None
11. Industry or business Retired Auto Salesman

FATHER
12. Name James Jarrett -D
13. Birthplace Balto. Maryland

MOTHER
14. Maiden Name Sarah Riley
15. Birthplace Hanover, Pa

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

1947 NOV 12 1947
(Date rec'd by registrar) Registrar

V S 150

correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10- 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29- 1947 to 11-10- 1947, and that I last saw h im alive on 11-10- 1947

Immediate cause of death	Duration
Carcinomatosis	
Bronchopneumonia	4 days
Due to Bronchogenic Carcinoma	7
Due to	
Other Conditions Carcinomatosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund B. Beahan M. D.
Address Balto City Hosp Date signed Nov 47

X

56852 B.C.# 4-13426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G56852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts.
(c) Hospital or institution:
Franklin Square Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 43hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Stanley James Lubinski, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Newborn

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 8, 1947

8. AGE: Years	Months	Days	If less than one day
		1	19 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Stanley James Lubinski, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rose Marie Grass
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Rose Lubinski
(b) Address 1129 E. Baltimore Street

17 (a) Burial (b) Date thereof Nov 12 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Marion W. Dyer & Sons
(b) Address Lombard & Eutaw
NOV 12 1947 (Date rec'd by Registrar) Lovington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1947, at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/47 19... to 11/10/47 19...
and that I last saw him alive on 11/10/47 19...

Immediate cause of death	Duration
Intra Cranial Hemorrhage	
Due to	
Due to	
Other Conditions Atelectasis	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature Chas. W. Cahn M. D.
Address 245 W. Balto St. Date signed 11/11/47

File the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

6853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Reg. No. 656853

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Saint Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Bayard Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Smith

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jessie 60
6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.) 3 | 12 | (18)84

8. AGE: Years: 63 (56) | Months: 7 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Anne Arundel Co. (Town, county, and state)

10. Usual Occupation: Huckster

11. Industry or business

FATHER 12. Name: Wm. H. Smith
13. Birthplace: Anne Arundel County

MOTHER 14. Maiden Name: Ella Smith
15. Birthplace: Anne Arundel County

16 (a) Informant: James Smith
(b) Address: 1317 Bayard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-47 (month) (day) (year)
(c) Cemetery or crematory: Columbus Mem'l Pk
Location: Balto County Md

18 (a) Funeral director: Chas G Corbin
(b) Address: 510-12 Carrollton Ave.

19 NOV 12 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Nov. 8, 1947, at 2 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions Generalized arteriosclerosis
Fractured ribs, left, 9-11
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following: 21/2

(a) Date of injury 11-6-47 at 4:30 P. M.
(b) Where did injury occur? Hamburg & Bayard Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stumbled and fell to ground

23. Signature [signature] M.D. Medical Examiner.
Date signed 11-8-47

G56854 BALTIMORE CITY HEALTH DEPARTMENT G56854
CERTIFICATE OF DEATH 13B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 953 Bennett Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia Wilks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
femal	colord	sep.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-3-24

8. AGE: Years	Months	Days	If less than one day
23	4	4	hr. min.

9. Birthplace N. C. (Town, county and state)
10. Usual Occupation Town Dresser,
11. Industry or business

FATHER
12. Name John Wilks
13. Birthplace S. C

MOTHER
14. Maiden Name Janie Carter
15. Birthplace S. C.

16 (a) Informant Mrs James Wilkes
(b) Address 953 Bennett Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St.

NOV 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1947, at 5 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9 1947 to Nov. 7 1947, and that I last saw him alive on Nov. 7 1947.

Immediate cause of death	Duration
Pericarditis	
Due to Tubercle Bacilli	
Due to	
Other Conditions Tuberculous Pleurisy	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Asked

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman M. Mellinkoff M. D.
Address Johns Hopkins Hosp. Date signed 11/7/47

90B

Correct age is especially important. Physicians: please write the

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56855 — 937 — Registered No. G56855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 S. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 S. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pauline Elizabeth Jensen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Henry

6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) July 21 1868

8. AGE: Years 79 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John G. Groener
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Henry Jensen
(b) Address 318 S. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frent Ave.

18 (a) Funeral director Geo. H. Leimbach
(b) Address 1 W. N. Eutaw St.

NOV 12 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1947, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 1947, to Nov 11 1947, and that I last saw h.. alive on Nov. 9 1947

Immediate cause of death Cerebral hemorrhage — Duration 1

Due to Atheroma

Due to —

Other Conditions Myrenditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Max Murphy M. D.
Address 801 Bruen St (Date signed)

83a 11/11/47

Please write plainly. Correct name and address of informant are important. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

56850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G56850 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 N. Port Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 N. Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie K. Moxley

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. Moxley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1866

8. AGE: Years	Months	Days	If less than one day
81	2	1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Geo. Schluderberg
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Frank
15. Birthplace Germany

16 (a) Informant Walter Moxley
(b) Address 418 N. Port Street

17 (a) Burial (b) Date thereof Nov. 14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Schwartz's Cem.
Location Balto, Md.
18 (a) Funeral director Philip Steurg Sons
(b) Address 2024 Orleans St.
19 (a) NOV 12 1947 (b) Huntington Williams M.D.
(Date received) (Local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Nov 10 1947 and that I last saw h[illegible] alive on Nov 10 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	1/2 hr.
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry F. Corse M. D.
Address 2607 Fraser Date signed 11-12-47

Physicians: please write the correct age is especially important.

A-M S-150

6857 Sec 5143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G56857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 S. Arlington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1047 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mary McCormick

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1882

8. AGE: Years	Months	Days	If less than one day
64	10	14	hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Aaron Shepherd
13. Birthplace New Jersey

MOTHER
14. Maiden Name Sarah E. Thompson
15. Birthplace Washington, D.C.

16 (a) Informant Mrs Lillie M. Myers
(b) Address 100 S. Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-47 (month) (day) (year)
(c) Cemetery or crematory Westwood
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 200 W. Lombard St.

19 NOV 12 1947 (b) Baltimore, Md.
(Date received by Registrar)

DS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Death on Arrival 19, and that I last saw h alive on 19.

Immediate cause of death: Acute Cardiac failure — Duration: Immediate

Due to: Hypertensive cardio-vascular disease — Duration: years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Tommasello M. D.
Address 910 W. Lombard St. Date signed 11 Nov 47

Howard J. Bruccia, M.D.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

56858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56858 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1327 N. Stockton
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 Stockton St (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Alberta Shaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed.

6 (b) Name of husband or wife Joseph Shaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec ? 1863

8. AGE: Years	Months	Days	If less than one day
83	11	?	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Phelonia Thomas
(b) Address 1327 N Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. W. Kelly
(b) Address 1303 Druid Hill Ave

19 NOV 12 1947 Date rec'd by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1947, to Nov 8 1947, and that I last saw h[illegible] alive on Nov 1 1947.

Immediate cause of death	Duration
Cardio Vascular Disease	1 yr.
Due to Broken Complication	4 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 1928 Penna Ave Date signed 11/12/47

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6859 C-111948 — 1251B — Registered No. G56859

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitlas
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Aisquith Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Stevenson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14-1902

8. AGE: Years	Months	Days	If less than one day
44	10	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name Harry G. Stevenson
13. Birthplace Maryland

MOTHER — 14. Maiden Name Corrie E. Brown
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-14-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Rd

18 (a) Funeral director Joseph Sarace Inc
(b) Address 203 Fleetwood Ave

NOV 12 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1947, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 19 47 to Nov. 11 19 47, and that I last saw h 1m alive on Nov. 11 1947

Immediate cause of death	Duration
Bronchopneumonia	5 days
Due to	
Due to (or)	
Other Conditions Bilius cortigid degeneration - ? Pickslivers	

(Whether pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Confirmed degeneration of liver

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Julius Stolt, Jr. M. D.
Address Balt. City Hosp. Date signed 11/11/47

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Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Please correct age is especially important.

G56860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G56860

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 W. NORTH AVE.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 5 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 W. NORTH AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LULA BARTON EVANS

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	MARRIED

6 (b) Name of husband or wife EDW. DAVID EVANS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 9, 1879

8. AGE: Years	Months	Days	If less than one day
68	4	2	hr. min.

9. Birthplace FAYETTE CO. PENNA.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name WM. BARTON
13. Birthplace FAYETTE CO. PA.

MOTHER
14. Maiden Name LAURA TODD
15. Birthplace FAYETTE CO. PA.

16 (a) Informant MARGARET E. EVANS
(b) Address 1918 W. NORTH AVE.

17 (a) BURIAL (b) Date thereof NOV. 14, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEMETERY
Location UNIONTOWN, PENNSYLVANIA

18 (a) Funeral director Walter Burdge Bradley
(b) Address 1822 W. North Avenue

NOV 12 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 November 1947, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7/47 19 to Nov 10/47 19, and that I last saw h alive on Nov 10/47 19.

Cause of death: Coronary thrombosis — Duration yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Thomas M.D.
Address 624 N. Monroe Date signed 11/13/47

correct age is especially important. Physicians: please write clearly.

VS 150

G56861 &-88134 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56861

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 E. Madison Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 E. Madison Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD J. ELLERBEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5-1947

8. AGE: Years	Months	Days	If less than one day
	2	4	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name David Love
13. Birthplace Baltimore

MOTHER
14. Maiden Name Daisy Ellerbe
15. Birthplace Baltimore

16 (a) Informant Daisy Ellerbe.
(b) Address 1208 E. Madison St

17 (a) Burial (b) Date thereof 11 12 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location C. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) Date received by registrar NOV 12 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1947, at 2.15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation from aspiration of vomitus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at 10/2 M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11-10-47

VS 191

G56862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G56862

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26 S. East Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 65. 2 19

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 S. East Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH M. BUCHTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, ~~widowed~~, or ~~divorced~~

6 (b) Name of husband or wife August H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/1882

8. AGE: Years 65 | Months 2 | Days 19 | If less than one day ....hr. ....min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick Concannon
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Feeney
15. Birthplace Ireland

16 (a) Informant August H Buchter
(b) Address 26 S. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15 1947 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location 7300 Eastern Ave

18 (a) Funeral director John A. Moran
(b) Address 3900 E. Balt. St.

NOV 12 1947 Thurlington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 13 - 1947, at 5P. M

21. I certify that death occurred on the date above stated; that I attended deceased from SUDDEN DEATH, 19...., and that I last saw h.... alive on ....19....

Immediate cause of death	Duration
ACUTE CARDIAC DILITATION.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....., at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen S. Buchan
Address 3139 E. Balto St Date signed 11-18- M. D.

John R. Davis, M.D.
per: Earl L Ryan M.D.

VS 150 TO BE APPROVED

Cause of death entry and agency. Physicians: please write the causes of death clearly and legibly. Accurate statement of age is especially important.

G56863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56863 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4409 Norwood Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Norwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELSIE MAE HOLBROOK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife E. Gordon Holbrook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, ~~1885~~ 1887

8. AGE: Years	Months	Days	If less than one day
60 (62)	5	0	hr. min.

9. Birthplace Clarington, Ohio
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William Abersold
13. Birthplace W. Va.

MOTHER
14. Maiden Name Ellen Mellott
15. Birthplace Ohio

16 (a) Informant Mr. E. Gordon Holbrook
(b) Address 4409 Norwood Rd.

17 (a) Removal (b) Date thereof 11/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Bellaire, Ohio

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

Nov 12 1947 (b) Clarington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1947 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from at death bed to 19 , and that I last saw h[illegible] alive on 11/9 1947.

Immediate cause of death	Duration
1887 Heart failure - left	1 hour
Due to coronary occlusion	3 hours
Due to Arterial hypertension	years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Sprunt M. D.
Address 1072 N. Calvert St. Date signed 11/10/47
Thomas J. Mannix, M.D.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

G56864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G56864 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sinai Home. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Rosa (ROSE ROSS.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ George W. Ross.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24th. 1871.

8. AGE: Years 76 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business

MOTHER / FATHER

12. Name Nathan Rosenau,

13. Birthplace Germany.

14. Maiden Name ? Braun,

15. Birthplace Germany.

16 (a) Informant Mr. George W. Ross (Son.)

(b) Address 10 E. Eager St.

17 (a) Rem. & Burial (Burial, cremation, or removal) (b) Date thereof 11/13/47. (month) (day) (year)

(c) Cemetery ~~or crematory~~ Prospect Hill

Location York, Pa.

18 (a) Funeral director David Lord Undertaking Co.

(b) Address 1902 Eutaw Place.

19 (a) (Date received by registrar) (b) Registrar

NOV 12 1947

1/5 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1947, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1947 to 11/11 1947, and that I last saw her alive on 11/11 1947.

Immediate cause of death	Duration
(a) Carcinoma rectum.	
Due to (b) pneumonia	
Due to (c)	
Other Conditions Hypertension Carcinoma Rectum	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ca of rectum. Pneumonia.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herman M. Braun M. D.

Address Sinai Hospital Date signed 11/11/47

83a

Please write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

G56865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G56865
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 N. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A. Michael

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Horace Winton Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 188[illegible]

8. AGE: Years	Months	Days	If less than one day
65	11	28	hr. min.

9. Birthplace Hanover, Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Harry C. Slagle
13. Birthplace Pa.

MOTHER
14. Maiden Name Jane Franklin
15. Birthplace Pa.

16 (a) Informant Mr. J. Fred Kreissig
(b) Address 810 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13/47.
(month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Hanover, Pa.

18 (a) Funeral director Harry H. Deitzler
(b) Address 4101 Edmondson Ave.

NOV 12 1947 (b)
(Date received by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10/47. 19 , at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16. 1947. to Nov 10. 1947. and that I last saw h[illegible] alive on Nov 9 1947.

Immediate cause of death Cerebral Embolism — Duration: Immediate

Due to Arteriosclerosis — Duration: ?

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation October 16, 1947

Major findings of operation: Strangulated Hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Dr. Walter Spurrier M.D.

Address 603 Edmondson Ave Date signed 11/11/47

M. D.

Please write the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G56866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56866 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3927 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3927 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lauren W. Brannan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife K. Frances Brannan nee Slack 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1911.

8. AGE: Years	Months	Days	If less than one day
36	9	8	hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation Transportation Dept.
11. Industry or business Baltimore Transit Co.

FATHER
12. Name E. Thomas Brannan
13. Birthplace Md.

MOTHER
14. Maiden Name Simmons
15. Birthplace Wash. D. C.

16 (a) Informant wife Mrs. Katharine Frances Brannan
(b) Address 3927 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14/47 (month) (day) (year)
(c) Cemetery or crematory Mt. View
Location Howard Co. Md.

18 (a) Funeral director Harry H. Wirtz
(b) Address 4101 Edmondson Ave.
(c) 19 Nov 12 1947 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10/47. 19 , at 3p M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1947 to 11-10 1947 and that I last saw h alive on 11-10 1947

Immediate cause of death Coronary Occlusion — Duration few hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H R Johnson
Address 403 Med Arts Date signed 11-11-47 M.D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

Dr. F.R. Davis - 11/12/47 Attended J. Mulfeeny M.D.

correct age is especially important. Physicians: please write the

G56867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G56867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 South Rose Street
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days) ....
(e) Length of stay in Baltimore (yrs., mos., or days) ....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 South Rose Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country ....

3 (a) FULL NAME JAMES V. SAFAR (SCHAFFER)

3 (b) If veteran, name war ....
3 (c) Social Security Account No. ....

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Theresa
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1871

8. AGE: Years 76 | Months 2 | Days 11 10 | If less than one day ... hr. ... min.

9. Birthplace Czeck (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business ....

FATHER
12. Name Unk.
13. Birthplace ....

MOTHER
14. Maiden Name Unk.
15. Birthplace ....

16 (a) Informant John Safar
(b) Address 704 South Rose Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road
18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe Street

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1947, at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to Nov 11 1947, and that I last saw h[im] alive on Nov 10 1947.

	Duration
Immediate cause of death Arteriosclerosis	
Pulmonary Tuberculosis	10-15-47
Terminal failure	11-13-47
Due to Acute coronary occlusion	
Due to	
Other Conditions Nil	

(Include pregnancy within 3 months of death)
Date of operation Nil
Major findings of operation: ....
of autopsy: Nil

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ....
(b) Date of occurrence .... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ....
(e) Means of injury ....
23. Signature .... M. D.
Address .... Date signed ....

Correct age is especially important. Physicians: please write the c[lear]ly.

G56868 ✓ G56868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Pratt Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Winchester

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed.

6 (b) Name of husband or wife ?
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name John Van Meter
13. Birthplace ?

MOTHER
14. Maiden Name Anna O'Brien
15. Birthplace Baltimore, Md.

16 (a) Informant Henry Winchester
(b) Address 2611 E. Fairmount Ave.

17 (a) Burial (b) Date thereof 11-15-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Edgewood Oaklawn
Location Harford Road

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe Street

19 (a) [illegible] Livingston Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1947, at 930 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1947, to Nov 11 1947, and that I last saw h[illegible] alive on Nov. 11 1947.

	Duration
Immediate cause of death Uremia	#1 week
Due to Bilateral nephrolithiasis	4 years.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert J. Johnson M.D.
Address Mercy Hospital Date signed 11/11/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Be sure that the correct age is especially important.

X

G56869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

839

G56869
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution:
ST. JOSEPHS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1964 N. PATTERSON PK. AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MR. STANLEY VALARIAN WYCZALEK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife NONE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/20/03

8. AGE: Years	Months	Days	If less than one day
44	9	21	hr. min.

9. Birthplace BALTIMORE - MD.
(Town, county, and state)

10. Usual Occupation NOT EMPLOYED.

11. Industry or business

FATHER
12. Name Roman Wyczalek
13. Birthplace ?

MOTHER
14. Maiden Name Mary Kwarcina
15. Birthplace ?

16 (a) Informant Mary Kwarcina (mother)
(b) Address 1964 N. Patterson Park Avenue

17 (a) Burial (b) Date thereof 11/14/1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe Street

19 (a) (b)
(Signature of local registrar) Registrar

VS-130

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1947 at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9/ 1947 to 11/10 1947, and that I last saw h[illegible] alive on 11/10 1947.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration

Due to HYPERTENSION

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry J. Hruska M.D.
Address St. Jos. Hosp. Date signed 11/10/47

Huntington Hillcrest, M.D.

X

The cause of death clearly and legibly. Physicians: please write the correct age is especially important.

G56870 ✓ G56870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 Steiger Way
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-4
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Md
(c) City or town 1122 Steiger Way
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 Steiger "
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Jakielski

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Sngl

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of decreased (mo., day, yr.) Jan 19. 1937

8. AGE: Years 15 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER 12. Name John
13. Birthplace Wilmington Del

MOTHER 14. Maiden Name Anna Queen
15. Birthplace Balto Md

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Nov 14. 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto City

18 (a) Funeral director L. Neumann & Son
(b) Address 6067 Harford Rd

NOV 12 1947 (b)
(Date received by registrar)

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11, 1947 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1947 to Nov 11 1947 and that I last saw h[illegible] alive on Nov 7 1947

Immediate cause of death Ca of Throat — Duration

Due to I.B.C. of both Lungs

Due to Sprains - due to Bath accident

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Coral London M. D.
Address 2201 W. North Ave Date signed 11-11-47

X

The cause of death briefly and correctly is especially important. Physicians: please write legibly.

D. 056871 ✓ Q56874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. Q56874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Mary's
(c) City or town Leonardtown Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-47

8. AGE: Years	Months	Days	If less than one day
		1	hr. 28 min.

9. Birthplace LEONARDTOWN, MD. (Town, county, and state)

10. Usual Occupation ST. MARYS. MD.

11. Industry or business

MOTHER | FATHER

12. Name Thomas Bond

13. Birthplace Leonardstown

14. Maiden Name Marguerite, Battenly

15. Birthplace Leonardstown, Md.

16 (a) Informant Records

(b) Address

17 (a) Burial (b) Date thereof 11 | 13 | 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Our Lady Chapel
Location near Leonardtown, Md.

18 (a) Funeral director Wm. Boatting Leonard

(b) Address Leonardtown, Md.

19 (a) (b)
(Date received by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 11, 1947 at 12 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1947 to 19, and that I last saw h alive on 19.

Immediate cause of death P. O. A.
PREMATURITY

Due to ASPHYXIA NEONATORUM

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willegene A. Spencer M. D.

Address Johns Hopkins Hospital Date signed Nov-11 1947

Thomas J. Hanson, M.D.

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

G56872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56872 Registered No.

PLEASE WRITE PLAINLY, with ink or indelible pencil. Physicians: please write the causes of death clearly and legibly. Use no abbreviations or ditto marks. Be sure that every question is answered. Where the word "None" is correct, write it in full. Do not write in the space marked "Registrar's Use Only" or "For Registrar." Your certificate is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3906 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ella T. Reed

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Albert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15, 1872

8. AGE: Years 75 | Months 1 | Days 27 26 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and State)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Peter Farrell
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Egan
15. Birthplace Ireland

16 (a) Informant James Reed
(b) Address 3906 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 13 (day) 47 (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton and Fayette Sts.

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1947, at 3:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 1945 to 11/11 1947, and that I last saw h[illegible] alive on 11/10 1947.

Immediate cause of death	Duration
Bronchial Pneumonia	2 days
Due to Arteriosclerotic Cardiovascular Disease	5+ Years
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature]
Address 3611 Edmondson Date signed 11/11/47 M.D.

VS 180

G56873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G56873 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPHS HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 ECKINGTON AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ERB GRENVILLE LEE

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 216-10-2063

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MAMIE VIOLA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/6/90

8. AGE: Years	Months	Days	If less than one day
56	11	6	hr. min.

9. Birthplace UNIONTOWN, MD. (Town, county, and state)
10. Usual Occupation WAREHOUSE MGR.
11. Industry or business A.G. GOLDENBERG

FATHER
12. Name E. Lee Erb
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Fowler Erb
15. Birthplace Maryland

16. (a) Informant Mrs Earle Wilhide
(b) Address Union Bridge R.D. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15-47 (month) (day) (year)
(c) Cemetery or crematory Methodist Cemetery
Location Uniontown Maryland

18 (a) Funeral director D.J. Hartley & Sons
(b) Union Bridge & Westminster, Md

19 (a) (Date rec'd by registrar) (b) Registrar

Correct age is especially important. Physicians: please write the CAUSES OF DEATH clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1947 at 8:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7 1947 to 11/12 1947, and that I last saw h/~~m~~ alive on 11/12 1947

Immediate cause of death RESPIRATORY FAILURE

Due to BILATERAL PNEUMONIA
CEREBRAL VASC. ACCIDENT

Due to BILATERAL PNEUMONIA

Other Conditions COPD CBA

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation BILATERAL PNEUMONIA

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry P. Porter M.D.
Address St. Joseph's Hosp Date signed 11/13/47

NOV 12 1947

Hampton for Williams, Md

X

G56874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G56874
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3621 Forest Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3621 Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID ROBERT FALLON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife S. Neta Fallon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1876

8. AGE: Years	Months	Days	If less than one day
71	3	10	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Supervisor of Inventory Accts.
11. Industry or business State Roads Commission

FATHER
12. Name Daniel Fallon
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Patterson
15. Birthplace Md.

16 (a) Informant Mrs. Wilbur Coyle, Jr.
(b) Address 3621 Forest Park Ave.

17 (a) Burial (b) Date thereof 11/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Govan's, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (c) NOV 12 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1947, at 1:00p M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21 1939 to 11/11 1947. and that I last saw h[illegible] alive on 11/10/1947.

Immediate cause of death Chronic Myocarditis — Duration 5 yrs.
Due to Arteriosclerosis — 15 yrs
Due to —
Other Conditions Peptic Ulcer — 2 yrs

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 3403 Garrison Blvd. Date signed 11/12/47

937

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G56875 BALTIMORE CITY HEALTH DEPARTMENT G56875
Registered No.

CERTIFICATE OF DEATH 150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2328 Calverton Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2328 Calverton Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY R. WEST

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Charles J. West
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 4, 1874

8. AGE: Years: 72 | Months: 11 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Charles A. Henze
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary Key
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Edward C. Yeager
(b) Address: 2330 Calverton Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 NOV 12 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1947, at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1947, to Nov. 9 1947, and that I last saw her alive on Nov. 9, 1947.

	Duration
Immediate cause of death: Adenocarcinoma of left breast with metastasis.	7 mos
Due to:	
Due to:	
Other Conditions: Hypertension Secondary anemia (Include pregnancy within 3 months of death)	

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Daniel J. Schwartz M. D.
Address: 2320 Eutaw Place Date signed 11/10/47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G56876

441693

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G56876

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel Co
(c) City or town Galesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lindsey

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/26

8. AGE: Years	Months	Days	If less than one day
21	5	23	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Oyster house worker
11. Industry or business

FATHER
12. Name Frank Lindsey
13. Birthplace Va.

MOTHER
14. Maiden Name Fannie Duvall
15. Birthplace Md

16 (a) Informant FRANK Lindsey
(b) Address Galesville Md

17 (a) Burial (b) Date thereof 11/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chews
Location West River Md

18 (a) Funeral director J. D. Hurley & Son
(b) Address Galesville Md
(b) Funtington Williams Asst.

NOV 12 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1947, at 5.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1947 to 11/12 1947, and that I last saw him alive on 11/12 1947

Immediate cause of death: Typhoid fever — Duration: 3½ wks
Due to
Due to
Other Conditions Hemolytic anemia — 1 wk
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M.D.
Address Johns Hopkins Hosp Date signed 12 Nov 47

Please write or type. Physicians: please write the causes of death clearly and legibly. Underline the correct age is especially important.

VS 150

G56877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6

G56877 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd + Herring Run
(c) Hospital or institution:
Sydenham 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 File Ct.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roger Bruce Lilley ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-31-41

8. AGE: Years	Months	Days	If less than one day
6	9	12	hr. min.

9. Birthplace Pitt Co., North Carolina
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Thad Layfette Lilley
13. Birthplace Pitt Co., North Carolina

MOTHER
14. Maiden Name May Nanney
15. Birthplace Greenville, South Carolina

16 (a) Informant Thad Lilley
(b) Address 1219 File Court, Balt. City

17 (a) Removal (b) Date thereof Nov 15 194
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenwood Tarboro N.C.
Location Tarboro N.C.

18 (a) Funeral director Wm Cook Lee
(b) Address 217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1947, at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11-1947 to 1-12-1947, and that I last saw him alive on 1-12-1947

	Duration
Immediate cause of death Respiratory failure	immediate
Due to Meningococcemia with	24 hrs
Due to Meningococcus meningitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Cugler, Jr. M. D.
Address Sydenham Hospital Date signed 1-12-47

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

G56878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G56878
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Fayette St
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Marshall St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. FULL NAME Edgar A Upperman

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-9345

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Nellie Upperman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 22nd 1890
8. AGE: Years 57 Months 8 Days 20 If less than one day hr. min.
9. Birthplace Balto. Maryland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Journeyman

FATHER
12. Name Chas. M. Upperman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Alice MacKessen
15. Birthplace Balto. Md.

16 (a) Informant Chas. M. Upperman
(b) Address 1316 W. Lexington St

17 (a) Burial (b) Date thereof 11/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 127 St Paul St

19 (a) NOV 13 1947 (Date rec'd by registrar) (b) Function for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1947, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1947, to Nov 12 1947, and that I last saw him alive on Nov 12 1947.

Immediate cause of death	Duration
Pneumonia, bilateral	1 wk.
Due to	
Due to	
Other Conditions Arteriosclerotic heart disease with failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold Dillon M.D.
Address South Balto Gen. Date signed 11/12/47

PLEASE WRITE PLAINLY, with unfading ink. Answer all questions. Be sure to give correct age in each case, as this is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G56879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G56879 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 7
(d) Street No. 335 W. 29th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Arven

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank Arven
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1883

8. AGE: Years 63 | Months 11 | Days 18 | If less than one day ? hr. min.

9. Birthplace Constantinople, Turkey (Town, county, and state)
10. Usual Occupation Hwf.
11. Industry or business

FATHER
12. Name Elia Reides
13. Birthplace Constantinople Turkey

MOTHER
14. Maiden Name ?
15. Birthplace Constantinople Turkey

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Off Washington Blvd.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1947, at 9 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1947, to Nov. 10 1947, and that I last saw her alive on Nov. 10 1947.

Immediate cause of death: Diabetes mellitus with coma — Duration: UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John Le Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 11/12/47

PLEASE WRITE PLAINLY. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

V S 190

X

656880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 935

Register No. 656880

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2521 Shirley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days) 43yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2521 Shirley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Katzoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Krivoy
13. Birthplace Russia

MOTHER 14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Goldie Katzoff
(b) Address 2521 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 (a) NOV 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12-1947, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1947, to Nov 12 1947, and that I last saw h[illegible] alive on Nov 12 1947

Immediate cause of death	Duration
Myocarditis,	
Coronary Thrombosis	
Due to (occlusion)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Kaden M. D.
Address 2306 Eutaw Pl Date signed 11-12-47

V S 150

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

56881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G56881 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3913- Bareva Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3913- Bareva Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORTON COHEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 34 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Radio Repair

11. Industry or business

FATHER
12. Name Benjamin Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Annie
15. Birthplace Russia

16 (a) Informant Nettie Cohen
(b) Address 3913 Bareva Road

17 (a) Burial (b) Date thereof 11-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Philad Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2619 Eutaw Place

19 (a) NOV 13 1947 Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1947, at 9.30a M

21. I certify that I took charge of the remains described above, held an autop & insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullis M.D.
Medical Examiner.
Date signed 11-12-47

X

56882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. C56882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Holland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Parkton, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Laurence McCadden
13. Birthplace Parkton, Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Charles H. Harris
(b) Address 1119 Holland St
17 (a) Burial (b) Date thereof 11-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Stablesville
Location Parkton Md
18 (a) Funeral director Frank H. Seitz
(b) Address 864 N. 36 St
19 (a) NOV 13 1947 (Date rec'd by registrar) (Signature for Williams M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1947, at 3 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fatty degenerations of liver
Chronic glomerular nephritis
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Ryer M.D.
Medical Examiner
Date signed 11-11-47

correct age is especially important. Instructions, page

VS 151

56883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C56883

30D JUNE

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11-
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Homeless (If outside city or town limits, write RURAL and give town)
(d) Street No. NU (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Hobbs ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Colored Female

5. Color or race

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation House maid

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)
(c) Cemetery or crematory 11-13-47
Location Mt. Auburn

18 (a) Funeral director Wm. A. Jackson
(b) Address 916 Penna ave

19 (a) NOV 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.E.

MEDICAL CERTIFICATION 56

20. DATE OF DEATH November 5, 1947, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Syphilitic Aortitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Rogers M.D. (Medical Examiner)
Date signed

correct age is especially important. Physicians, please write plainly.

VS 151

Baltimore City Health Dept.

56884 MARYLAND STATE DEPARTMENT OF HEALTH G56884

CERTIFICATE OF DEATH 937

Reg. Dist. No.

PLACE OF DEATH:
City Baltimore
Town Pine Ridge Convalescent Home
(If outside city or town limits, write RURAL and give nearest town)
Length in above place of death? 2 days
Hospital, institution, or street address where death occurred:
4703 Hampnett Ave.
Length in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. 512 Middle River Road
(If rural, give LOCATION)
2.(a) If veteran, name war

1. FULL NAME THOMAS PUGH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

Name of husband or wife Doudet E. Pugh
6.(c) If alive, give age years
7. Date of birth of deceased (mo., day, yr.) 1870

AGE:	Years	Months	Days	If less than one day
	77			hrs. min.

Birthplace Balto. Co., Md.
(Town, county, and state)
Usual occupation Retired
Industry or business
12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown
Informant Mr. Wm. L. Bartels
Address 504 Middle River Rd.
burial Date thereof Nov. 14, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Moreland Memorial
Location Balto., Md.
Funeral director Lansdale Funeral Home
Address 7401 Belair Road
NOV 13 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1947 at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1944 to November 1947 and that I last saw h. IM. alive on November 11 1947

	DURATION
Immediate cause of death Azotemia	
Arteriosclerosis	
Due to Arterio-Sclerotic Heart Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph F. Sheehan M.D.
M. D. or other
Address Aberdeen, Md. Date signed Nov 17, 47

56885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 83a

Registered No. G56885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Poplar Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. HARTMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Harry Hartman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1872

8. AGE: Years	Months	Days	If less than one day
75	5	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John Schneider
13. Birthplace ?

MOTHER
14. Maiden Name Catherine
15. Birthplace ?

16 (a) Informant John H. Hartman
(b) Address 1217 Potter Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Fredreick Avenue

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe Street

19 NOV 13 1947 (Date received by Registrar) (b) Huntington Mills Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1947, to Nov 11 1947, and that I last saw her alive on Nov 10 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage - Uremia	2 days
Due to Arterial Hypertension & Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1901 [illegible] Place, City Date signed

X Culverhouse

PLEASE WRITE CLEARLY with pen and ink. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

56886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. 656886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hosp Baltimore 5, Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 12days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Arrowship Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Nelson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 20 47

8. AGE: Years — | Months — | Days 12 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Theodore Nelson
13. Birthplace Virginia

MOTHER
14. Maiden Name Elsie Frances
15. Birthplace

16 (a) Informant Theodore Nelson FATHER'S NAME
(b) Address 10 [illegible] Road.

17 (a) Burial/Removal (b) Date thereof 11/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lakeside
Location Dover Del.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) NOV 12 1947 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12/47 19__, at 5 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2/47 19__ to 11/12/47, and that I last saw him alive on 11/12/47 19__

Immediate cause of death: generalized peritonitis — Duration 6 days
Due to: Vanulus ileocecal 2days
Due to: Obstruction
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 11/7/47
Major findings of operation: Vanulus-ileocecal obstruction
of autopsy: generalized peritonitis

PHYSICIAN
Underline the cause to which it should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Bailey MD
Address St Joseph's Hosp Date signed 11/13/47

PLEASE WRITE CLEARLY. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

VS 150

G56887 S.C. #19585

AB-115006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G56887

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2560 Mace Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Chase

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 4-1947

8. AGE: Years | Months | Days | If less than one day: 19 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Raymond Chase
13. Birthplace S.C.

MOTHER
14. Maiden Name Mary Frances Holmes
15. Birthplace S.C.

16 (a) Informant Record-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof 11-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Crematory
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 (a) NOV 13 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5- 19 47 at 1.35PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4- 19 47 to 11-5- 1947 and that I last saw h in alive on 11-5- 19 47

Immediate cause of death: Prematurity — Duration: 19 hours

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold H Becker M. D.
Addr Balto City Hosp Date signed 11/9/47

G56888-4-93573 LW 115114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G56888

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Friedman(Ruth)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8-1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Friedman
13. Birthplace N.Y.

MOTHER
14. Maiden Name Ruth Weinhold
15. Birthplace N.Y.

16 (a) Informant B.C.H.Records
(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof 11-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Columatory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) NOV 13 1947 (b) Huntington Hollingsworth Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9- 1947, at 6:35A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8- 1947 to Nov. 9 1947, and that I last saw h. in alive on Nov. 9- 1947

Immediate cause of death	Duration
Prematurity	1day
Due to Fetal Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold H Becker M. D.
Address Balto City Hosp Date signed 11/14/47

C56889 - 115035 S-93590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V160a

Registered C56889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Laurens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Kerns - Elnor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1947

8. AGE: Years	Months	Days	If less than one day
			6 hr. 15 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Archie Watts
13. Birthplace Md.

MOTHER
14. Maiden Name Elnor Kerns
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11-8-47 (month) (day) (year)
(c) Cemetery or crematory Glenstone
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 (c) NOV 12 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1947, at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1947 to Nov. 6 1947 and that I last saw h. alive on Nov. 6 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Sub-tentorial hemorrhage	6 hrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Sub-tentorial Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Tyler Baker M. D.
Address Balt. City Hosp. Date signed 11-7-47

PLEASE WRITE PLAINLY. Be sure the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

V S 150

X

56890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1616

Registered No. G56890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7519 Belmont Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Victor Butta

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 13, 1947

8. AGE: Years	Months	Days	If less than one day
		29	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name John V. Butta
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Murray
15. Birthplace Ronceverte, Pocahontas Co. W. Va.

16 (a) Informant John V. Butta
(b) Address 7519 Belmont Ave.

17 (a) Burial (b) Date thereof 11-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Edward W. Conklin Sr.
(b) Address 924 E. Eager St.

19 NOV 13 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12 1947, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1947, to 11-12 1947, and that I last saw him alive on 11-1 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Septicemia (E. Coli)	
Due to Possible septic Thrombosis of Pancreas.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A R Mansberger Jr. M. D.
Address Univ. Hospital Date signed Nov 13 1947

PLEASE WRITE PLAINLY. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

56891 B.C.F. 1. 94260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160c

Registered No. C56891

PLEASE WRITE PLAINLY, with pencil or pen. Physicians: please write the causes of death clearly and legibly. Be sure that the information given in items 1 to 23 is complete and correct and that the certificate is signed. Information in items 24 to 30 is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 2
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 14 hrs
(e) Length of stay in Baltimore (~~yrs., mos., or days~~) 14 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4718 Alhambra Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BABY BOY HATTON

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10, 1947

8. AGE: Years	Months	Days	If less than one day
			14 hr. 10 min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name WILLIAM FRANCIS HATTON
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name JOSEPHINE RUTH COX
15. Birthplace Raglesville Va

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, ~~or removal~~) (b) Date thereof 11-12-47 (month) (day) (year)
(c) Cemetery or crematory
Location Union Memorial Hospital

18 (a) Funeral director
(b) Address

19 NOV 13 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1947, at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1947 to 11/11 1947 and that I last saw h~~im~~er alive on 11/11 1947.

Immediate cause of death	Duration
prematurity	
Due to premature birth of twin pregnancy	
Due to 22 wks pregnancy	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E B Chandler M.D.
Address Union Memorial Hosp Date signed 11/12

VS 150

G56892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G56892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dda
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Division St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Carrie Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1902

8. AGE: Years	Months	Days	If less than one day
45	7	19	hr. min.

9. Birthplace Granite, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William H. Bell
13. Birthplace Balto Co. Md.

MOTHER
14. Maiden Name Emma Johnson
15. Birthplace Hanover Co. Va.

16 (a) Informant Mrs. Richard Tyler
(b) Address 1926 Division St.

17 (a) Burial (b) Date thereof Nov. 14, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Eastern Star
Location Baltimore Co. Md.

18 (a) Funeral director Chas. H. Hall and Co.
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 13 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

correct age is especially important. Physicians, please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1947, at 6 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of head involving brain

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-10-47 5:00 P M.(?)
(b) Where did injury occur? 1926 Division St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? .....
(d) Means of injury Firearm

23. Signature Carl Reyburn M.D.
Medical Examiner.

Date signed 11-11-47

VS 181

G56893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146E

Registered No. G56893

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Give the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. Carrollton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Widowed

6 (b) Name of husband or wife Nanny

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/5/95

8. AGE: Years	Months	Days	If less than one day
51 yrs	11	5	hr. min.

9. Birthplace South Carolina
(Town, county, and State)

10. Usual Occupation Steve Keeper

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Lorraine Green
(b) Address 601 N. Carrollton Ave

17 (a) Burial (b) Date thereof Nov. 13 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Hadaway
(b) Address 1631 Druid Hill Ave

19 (a) NOV 13 1947 (b) Registrar
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1947, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1947 to 11/10 1947 and that I last saw h[illegible] alive on 11/10 1947

Immediate cause of death Intestinal Obstruction — Duration

Due to Carcinoma of Colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M. D.
Address 1514 Division Date signed 11/11/47

56894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C56894

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1339- N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Romeo BISHOP

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-12-6280 A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife Lottie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1/1875

8. AGE: Years	Months	Days	If less than one day
72	10	10	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name unobt

13. Birthplace Annapolis

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Lottie Bishop

(b) Address 1339 Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)

(c) Cemetery or crematory Calvaries

Location Md

18 (a) Funeral director Wm. H. Nelson

(b) Address 1303 Presstman St

19 (a) NOV 13 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1947, at 7.15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractures of pelvis, hip, tibia and fibula

Due to

Other Conditions Osteitis deformans

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-11-47. 7 P. M. 15/1

(b) Where did injury occur? Calhoun & Laurens St. Baltimore, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian-struck by taxi

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 11/12/47

correct age is especially important. Physicians: please write clearly.

VS 151

X

G56895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V132

G56895 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1518 Baker St
(b) Street address Balto Md
(c) Hospital or institution: 15-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County Md
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Baker St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 28-1908

8. AGE: Years	Months	Days	If less than one day
39	—	—	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business —

FATHER
12. Name Milton Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Smith
15. Birthplace Maryland

16 (a) Informant Mary Bond
(b) Address 1518 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wm. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) NOV 13 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1947, at — M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28-1947, to Nov 10 1947, and that I last saw h[illegible] alive on Oct 9-1947

Immediate cause of death Toxic Myocarditis — Duration About 1 mo

Due to Pustular Infection joints Knees, Hip + Sacro-Coccygeal joints — 5 yrs

Due to [redacted]

Other Conditions Nephritis, Anemia

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Wm R Boyd Kerr M. D.
Address 1173 Monroe Date signed 11/13/47

VS 2

166a

G56896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G56896

PLEASE WRITE PLAINLY, WITH CAUSES OF DEATH clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2732 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Ethel Skolkin ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	215-01-4933

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Joseph Skolkin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1901

8. AGE: Years	Months	Days	If less than one day
46	4	7	hr. min.

9. Birthplace Easton, Maryland (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER 12. Name Willard F. Price
13. Birthplace Trappe, Maryland

MOTHER 14. Maiden Name Elizabeth E. Woolford
15. Birthplace Maryland (Talbot Co)

16 (a) Informant Mr. Joseph Skolkin
(b) Address 2732 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or crematory Springhill Cem.
Location Easton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 13 1947 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 1947, to Nov. 12 1947, and that I last saw h.e.R. alive on Nov. 12 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Uraemia	
Chronic myocarditis	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Anemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Burkhart M.D.
Address Md. General Hosp. Date signed Dec 13, 1947

X

G56897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G56897

PLEASE WRITE PLAINLY, with unfading ink. Report one cause on a line. Do not use abbreviations or terms unless commonly understood. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6114 Greenspring Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6114 Greenspring Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES W. KLARNER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise S. Klarner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1875

8. AGE: Years	Months	Days	If less than one day
72	0	6	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: Herman Klarner
13. Birthplace: Germany

MOTHER
14. Maiden Name: Annetta Auer
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Louise S. Klarner
(b) Address: 6114 Greenspring Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 13 1947 (Date rec'd by registrar) (b) Filing Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1947, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 11/11/1947 and that I last saw h[illegible] alive on 11/11/1947

Immediate cause of death: Cerebral Hemorrhage
Cerebral Thrombosis
Senile Arteriosclerosis

Due to:

Due to:

Other Conditions: Prostatic Enlargement
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1422 Eutaw Pl. Date signed 11/12/47 M. D.

G56898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1130

G56898 Registered No.

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 1 St. Paul St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Louise Moultrie Juhan

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, ~~married, widowed, or divorced~~.

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1886

8. AGE: Years 61 | Months 1 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace Georgia (Macon) (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William J. Juhan
13. Birthplace Georgia (Macon)

MOTHER
14. Maiden Name Louisa Moultrie
15. Birthplace Georgia (Macon)

16 (a) Informant Hospital Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)
(c) Cemetery or crematory
Location Macon, Ga.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 12 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1947 at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1947 to Nov. 12 1947 and that I last saw h[illegible] alive on Nov. 12 1947.

Immediate cause of death	Duration
Uremia	
Due to Acute nephritis	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: C

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel S. Bedal, M.D.
Address Union Memorial Hospital Date signed 11/12/47

VS 150

G56899

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH ✓ 157E

Registered No. G56899

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Do not write the causes of death clearly and legibly. Physicians; please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Whitney
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Silas M. Grant, Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-4-46
8. AGE: Years 1 | Months 1 | Days 8 | If less than one day hr. min.
9. Birthplace Texas (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Dr. Silas M. Grant
13. Birthplace Ohio

MOTHER
14. Maiden Name Betty Griffith
15. Birthplace Texas

16 (a) Informant Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)
(c) Cemetery or crematory
Location Austin, Texas

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 13 1947 (Date rec'd by registrar) (b) Burington Williams, M.D.

MEDICAL CERTIFICATION 37

20. DATE OF DEATH Nov. 12 1947 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1947 to Nov 12 1947, and that I last saw him alive on Nov. 12 1947.

Immediate cause of death	Duration
Pulmonary edema	1d
post operative Congenital heart disease	since birth
Due to operation	
Due to congenital ailment Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/7/47
Major findings of operation: transposition of great vessels
of autopsy: unknown at present

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. C. SPENCER M. D.
Address Johns Hopkins Hosp. Date signed 11-12-47

VS 150

X

G56900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1124 B

Registered No. G56900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1539 Poplar Grove St.
(c) Hospital or institution: 15-C

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1539 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHRYN J. REED. I

3 (b) If veteran, name war: none.

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: James Reed.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7-1909.

8. AGE: Years 38 | Months 6 | Days 4 | If less than one day: hr. min.

9. Birthplace Germantown - Ohio. (Town, county, and state)

10. Usual Occupation Cashier.

11. Industry or business

FATHER
12. Name Edward Green.
13. Birthplace Md.

MOTHER
14. Maiden Name Mabel F. Long.
15. Birthplace Ohio.

16 (a) Informant Mrs. Sheldon Green.
(b) Address 1539 Poplar Grove St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Nov. 13-47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 351 E. Frederick, Md.

19 (a) NOV 13 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1947, at 6.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery Disease

Due to

Other Conditions Cirrhosis of Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl C. Rose M.D. (Medical Examiner.)
Date signed 11-12-47

correct age is especially important. Physicians: please write

VS 151

94a

56901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1639

Register No. G56901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(d) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1756 E. North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HILDA STARR (HILDA MARIE STARR)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-05-4949

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles P. Starr

6 (c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): Dec. 17, 1900

8. AGE: Years: 46 | Months: 10 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business: Shirtcraft Co.

FATHER
12. Name: James B. Beecher
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Henrietta M. Hampton
15. Birthplace: Maryland

16 (a) Informant: Charles P. Starr- husband
(b) Address: 1756 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem:
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) NOV 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 11, 1947, at 12.55 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fluoride poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-11-47 at 11 a. M.
(b) Where did injury occur? 1756 E.North Ave. Balto.Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury: Ingestion of (sod. fluoride) roach powder.

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 11-12-47

VS-151

correct age is especially important. Physicians: please write plainly.

G56902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45F

G56902 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st and Wyman Park Drive
(c) Hospital or institution: US Marine Hospital Balto.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) not stated

12 - 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Greece (b) County Chios
(c) City or town Apletaria (If outside city or town limits, write RURAL and give town)
(d) Street No. not given (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Greece

3 (a) FULL NAME Kolaros, Elias

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Maroca Kolaros
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) March 22, 1882
8. AGE: Years 65 | Months 2 | Days 10 | If less than one day ____ hr. ____ min.
9. Birthplace Apletaria, Chios, Greece (Town, county, and state)
10. Usual Occupation Greek seaman
11. Industry or business Sea faring

FATHER
12. Name Chara Lapes Kolaros
13. Birthplace Greece

MOTHER
14. Maiden Name Anna ?
15. Birthplace Greece

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-47 (month) (day) (year)
(c) Cemetery or crematory Cemetery Greek
Location Windsor Mill Rd
18 (a) Funeral director Lambros F.H. Inc
(b) Address 440 E. North ave
19 (a) NOV 19 1947 (Date received by registrar) (b) ____ Registrar
Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1947 19 ..., at 7.15 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1, 1947 to Nov. 10 1947, and that I last saw him alive on Nov. 9 1947

Immediate cause of death: Lymphoepithelioma, nasopharynx with metastases to cervical lymph nodes, right axillary nodes, lungs, liver, intercostal spaces (5th-left), heart — Duration: 4 months

Due to: ____

Due to: ____

Other Conditions: cervical cysts, left kidney exostosis left right — unknown

Date of operation: impossible (If pregnancy within 3 months of death)
Major findings of operations: —
of autopsy: as above

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____
23. Signature Agnes S Keane M.D.
Address Woodlawn Hosp Date signed 11/19/47

X

G56903

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 1947

Registered No. G56903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 420, Route 16,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steven Marhanka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1947

8. AGE: Years	Months	Days	If less than one day
	10		hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name John Marhanka
13. Birthplace Indiana

MOTHER
14. Maiden Name Elinor Keene
15. Birthplace Alabama

16 (a) Informant Father
(b) Address

17 (a) Removal (b) Date thereof 11-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Seymour Indiana

18 (a) Funeral director John G. Connelly
(b) Address 414 Eastern Ave. Essex 21

NOV 13 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1947, at 3.25 a M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
Due to Asphyxiation by Stomach contents
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner
Date signed 11-13-47

correct age is especially important. Physicians: please write plainly

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G56904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

G56904 Registered No.

PLEASE WRITE PLAINLY, WITH ONLY ABBREVIATIONS. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & green
(c) Hospital or institution: University 4-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. moose Club 410 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas F. Fitzberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 20-1884

8. AGE: Years 63 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business

FATHER 12. Name Thomas F

13. Birthplace Md.

MOTHER 14. Maiden Name Sophia Robinson

15. Birthplace Md

16 (a) Informant Mr. Robt. Fitzberger

(b) Address 1128 Cleveland Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Philip Herwig Sons

(b) Address 2024 Orleans st

[redacted] 19 47 Clayton Williams, M.D. Registrar
(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11-47 19 47 at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 19 47 to 11-11 19 47, and that I last saw h/M alive on 11-11 19 47

Immediate cause of death Toxemia — Duration

Due to Pneumonia

Due to

Other Conditions Congestive failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. B. Mearns M. D.

Address Mercy Hosp. Date signed 11-11-47

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G56905

BALTIMORE CITY HEALTH DEPARTMENT ✓ G56905

CERTIFICATE OF DEATH 171a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Pohler

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-6695

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Late Mary Pohler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1870

8. AGE: Years 77 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Mill worker

11. Industry or business National Casket Co

FATHER
12. Name Pohler
13. Birthplace Balto.

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mr. Frank Pohler
(b) Address Joppa Md. R.F.D. #49

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location "

18 (a) Funeral director Philip Herzig Sons
(b) Address 2024 Orleans St

19 (a) NOV 2 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1947 at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & subdural & subarachnoid Hemorrhage

Due to

Other Conditions Fracture of tibia Rt. 3-5

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-9-47 at 9:00 P.M. 8/7

(b) Where did injury occur? Washington & Preston Sts

(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no

(d) Means of injury Pedestrian struck by auto

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 11-9-47

X

Please write this correct age is especially important. Physicians:

G56906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56906 Registered No.

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made for each item. Physicians: please write the causes of death clearly and legibly. Information as to age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 LIGHT ST.
(c) Hospital or institution: SOUTH BALTO. GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 48 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Anne Arundel
(c) City or town ARUNDEL GARDENS (If outside city or town limits, write RURAL and give town)
(d) Street No. MAINE & CRESWELL AVES. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME RETZ, CLARA FREDA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Adolf Retz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20-1899

8. AGE: Years 48 | Months 0 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Louis C. Meyer
13. Birthplace Ohio

MOTHER
14. Maiden Name Hattie Luedtke
15. Birthplace Germany

16 (a) Informant Adolf Retz
(b) Address Maine & Creswell Aves.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

NOV 2 1947 (Date rec'd by registrar) (b) Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1947 at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1947 to Nov. 11 1947 and that I last saw her alive on Nov. 11 1947.

Immediate cause of death	Duration
Bac Tenemia & septicaemia	
Due to Clastridial group of organisms.	
Due to	
Other Conditions Diabetic gangrene right hand. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William B. Cogan Jr. M. D.
Address SOUTH BALTO. GEN. HOSP. Date signed 11/14/47

VS 150

24a

G56907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

G56907 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Bretton Place.-Guilford
(c) Hospital or institution: ---
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 -1
(e) Length of stay in Baltimore (yrs., mos., or days) About 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Bretton Place, Guilford.
(If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -------

3 (a) FULL NAME: ANNA HARDAWAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Col. Ben F. Hardaway

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---------- 1893

8. AGE: Years 54 | Months --- | Days -- | If less than one day -- hr. -- min.

9. Birthplace: New Bern, N. Carolina
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business: ------

FATHER
12. Name: Ulysses S. Mace
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Ella R. Gibbs
15. Birthplace: North Carolina

16 (a) Informant: Col. B. F. Hardaway
(b) Address: 403 Bretton Place

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location: New Bern, North Carolina

18 (a) Funeral director: H. W. Mears and Son
(b) Address: 805 N. Calvert Street

NOV 13 1947 (b) Washington, N.C.
(Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 12, 1947, at 7.40 A.M.

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to illuminating gas

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-12-47. 7 a. M. 403 Bretton Place
(b) Where did injury occur? Guilford-Balto.Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating gas

23. Signature: Earl L. Royer M.D.
Medical Examiner.
Date signed 11-12-47

correct age is especially important. Physicians: please write the

VS 151

G56908 BALTIMORE CITY HEALTH DEPARTMENT ✓ G56908

CERTIFICATE OF DEATH 1138

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South Balto. Gen. Hosp 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1747 Bolt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Ganoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1904

8. AGE: Years	Months	Days	If less than one day
43	5	15	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business

FATHER
12. Name Albert Ganoe
13. Birthplace West Va

MOTHER
14. Maiden Name Ida Wagner
15. Birthplace West Va.

16 (a) Informant deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Penna Ave Line Road
18 (a) Funeral director C. J. Fahey & Sons
(b) Address 1211 Light St
(a) NOV 12 1947 (Date rec'd by registrar) (b) Thomas Worthington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1947, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1947, to Nov 9 1947, and that I last saw him alive on Nov 8 1947.

Immediate cause of death: Pulmonary Tuberculosis
(a) advanced

Due to

Due to

Other Conditions Cirrhosis ? the liver
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Pilson
Address South Balto Gen Hosp Date signed (M.D.) 11/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

56909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56909

567

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4905 Liberty Hgts Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Maria Vanni

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Camillo Vanni
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/8/897

8. AGE: Years	Months	Days	If less than one day
50	5	4	hr. min.

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Marcello di Giovanni
13. Birthplace Italy

MOTHER
14. Maiden Name Grazie Mazzocchi
15. Birthplace Italy

16 (a) Informant Camillo Vanni
(b) Address 4509 Liberty Hgts av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Harry A Annacott
(b) Address 420 Edgewood Ave

19 (a) NOV 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12 1947, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1947, to 11-12 1947 and that I last saw her alive on 11-12 1947.

Immediate cause of death	Duration
Massive cerebral hemorrhage	
Due to Cerebral neoplasm	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration — over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address 1400 N. Caroline St Date signed 11-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Give correct age is especially important. Physicians: please write

VS 190

X

656910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. 656910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Employ undertaker to secure the necessary information. Report the causes of death clearly and legibly. Give correct age in all cases. Answer every question. If none, or not applicable, write NONE, so that there will be no occasion for inquiry. Particular attention is especially important. Physicians: please write the cause of death in such terms as will convey to the lay mind a clear understanding of the exact cause of death. Do not use abbreviations or technical terms.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3734 Hickory Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3734 Hickory Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David J. Lockner.

3 (b) If veteran, name war: 1st W. W.
3 (c) Social Security Account No. 214-20-0252

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Goldie E. Lockner
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) April 10, 1892

8. AGE: Years	Months	Days	If less than one day
55	7	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Huckster.
11. Industry or business

FATHER
12. Name Daniel Lockner.
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Smallwood
15. Birthplace Maryland

16 (a) Informant Mrs. Goldie E. Lockner
(b) Address 3734 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15/47. (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director Schumacher & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) NOV 13 1947 (Local registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1947, at 4 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1947 to Nov 13 1947, and that I last saw h[illegible] alive on Nov 12 1947

Immediate cause of death	Duration
Bronchogenic Carcinoma	
Due to	
Due to	
Other Conditions Carcinomatosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin J. Plasman M. D.
Address 4037 Eddy Rd Date signed 11/13/47

X

056911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered 056911

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 DIVISION ST
(c) Hospital or institution: PROVIDENT HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 E. Biddle St (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Charlie STOCKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Rachel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/4/1899

8. AGE: Years 48 Months 5 Days 7 If less than one day ..... hr. ..... min.

9. Birthplace Greenville N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Davison Chemical Co

FATHER
12. Name Hayward Stokes
13. Birthplace N. C.

MOTHER
14. Maiden Name Lydia Carr
15. Birthplace N. C.

16 (a) Informant Rachel Stokes
(b) Address 1301 E Biddle St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof NOV 13 47 (month) (day) (year)

(c) Cemetery or crematory
Location Forky Mt N. C.

18 (a) Funeral director Mrs Pitt G. Elliott
(b) Address 1129 N. Carrollton Ave
NOV 13 1947 (Date rec'd by registrar) (b) Funeral for Baltimore, Md. Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1947, at 10 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1947 to 11/11 1947, and that I last saw h.a.l.m alive on 11/11 1947

Immediate cause of death: Pulmonary congestion — Duration ?

Due to: Hypertensive C-V

Due to: Renal disease

Other Conditions: Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilkins Barnes M. D.
Address 1514 DIVISION ST Date signed 11/11/47

VS 150

X

656912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

Register's No. 656912

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6109 Fair Oaks Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 6109 Fair Oaks Ave.,
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Heinlein

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1869

8. AGE: Years 78 | Months 3 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Shoe Maker,
11. Industry or business Shoe Factory,

FATHER
12. Name John Heinlein,
13. Birthplace Germany,

MOTHER
14. Maiden Name Margaret Gissel,
15 Birthplace Baltimore, Md.

16 (a) Informant Miss S. Louisa Heinlein,
(b) Address 6109 Fair Oaks Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery,
Location Baltimore, City.

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights

19 NOV 13 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1947 at 11 45 a.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/16/ 1947 to 11/10/ 1947, and that I last saw him alive on 11/9/ 1947.

Immediate cause of death: Hypertensive cardio vascular renal disease. — Duration: 9

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Deibel, M.D.
Address 1226 Hanover St. Date signed 11/11/1947.

X

VS 193

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

G56913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56913 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered, or if unknown or if the question is not applicable, a dash (—) must be written. Do not use ditto marks. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4007 Hayward Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltr. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 Hayward Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard H. Knickman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie Knickman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1883

8. AGE: Years 64 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation Retired Business man

11. Industry or business Restaurant.

FATHER
12. Name Henry Knickman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Wolfe
15. Birthplace Germany

16 (a) Informant Mrs. Bessie Knickman.
(b) Address 4007 Hayward Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto. City

18 (a) Funeral director L. Vernon Lemmon
(b) Address 1906 11 Park Place

19 (a) (Date rec'd by registrar) Washington Williams M.D.

NOV 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Nov. 1947 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Sept. 1947 to 13 Nov. 1947 and that I last saw him alive on 7 Nov 1947.

	Duration
Immediate cause of death: Acute Ventricular Failure	—
Due to: Hypertensive Cardio Vascular Disease	4 mo.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.

Address 56 E Lexington St Date signed 13 Nov 47

VS 150

G56914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Norfolk Ave.
(If rural give location)
(e) Citizen of foreign country? Nat. (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E. Davis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Jennie Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 31, 1882

8. AGE: Years	Months	Days	If less than one day
65	9	11	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Saloon Keeper & Farmer
11. Industry or business

FATHER
12. Name John Henry Davis
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Florida Bennett
15. Birthplace Baltimore Md.

16 (a) Informant Sister
(b) Address

17 (a) Burial (b) Date thereof 11/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights

19 [redacted] (b) Huntington Williamsport, Md.
(Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1947, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1947 to 11/11 1947, and that I last saw him alive on 11/11 1947

Immediate cause of death Cerebral hemorrhage — Duration 12 hr

Due to Hypertension — Duration years

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Henry V. Shaw M. D.
Address Mercy Hospital Date signed 11/11/47

56915 LW 114503 BALTIMORE CITY HEALTH DEPARTMENT ✓ G56915

CERTIFICATE OF DEATH 46 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Alford Sweeting

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 6 1889 ?

8. AGE: Years 58 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charlie Sweeting
13. Birthplace ?

MOTHER 14. Maiden Name Sophie Bowman
15. Birthplace Va.

16 (a) Informant B.C.H.Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Nate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) NOV 13 1947 (Date rec'd by registrar) Mrs Nate R. Williams

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 11- 1947, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1947 to Nov. 11 1947, and that I last saw h. im alive on Nov. 11 1947

Immediate cause of death Surgical Shock — Duration: minutes / months / years

Anemia due to Blood Loss

Due to Carcinoma of Stomach with formation of gastro-colic fistula

Due to Metastatic tumor in Regional lymph nodes & neck

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Nov 4 47

Major findings of operation: above

of autopsy: above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: HIM

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 11-11-47 at M

(c) Where did injury occur? Balto City Hosp.
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No
(Specify)

(e) Means of injury Dr. [illegible] treating the

23. Signature Kash E. Kellerman M. D.

Address Balt. City Hosp. Date signed Nov 12, 47

Hon. Asst. Attending M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

To be approved by Medical Examiner

X SODIUM PENETHOL

McKENNEY

56916 — 193680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 56916

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W Va (b) County
(c) City or town Sophia (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Lee Kenney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	m

6 (b) Name of husband or wife Lola

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/9/04

8. AGE: Years	Months	Days	If less than one day
43	9	4	hr. min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Riley McKenney
13. Birthplace W. Va.

MOTHER
14. Maiden Name Polly Lester
15. Birthplace W. Va

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 13/47 (month) (day) (year)
(c) Cemetery or crematory Sophia W Va
Location Boone W Va

18 (a) Funeral director Ullom Funeral Home
(b) Address 2008 Oakley St Huntington West Virginia

19 NOV 13 1947 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 13 1947 19 , at 305 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/04 1947 to 11/13 1947. and that I last saw him alive on 11/13 1947.

Immediate cause of death	Duration
anuria + uremia	7 days
Due to Post operative renal hemorrhage	7 days
Due to	
Other Conditions Renal TBC + surgical absence of Lt. Kidney. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilford A. Connell Jr M. D.
Address Johns Hopkins Hosp. Date signed 11-13-47

VS 150

X

G56917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Register G56917

17 55561

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Pr. George's
(c) City or town Bowie
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Marie Fretwell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/10/47

8. AGE: Years	Months	Days	If less than one day
	5	3	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Allan Fretwell
13. Birthplace Va.

MOTHER 14. Maiden Name Mary Fretwell
15. Birthplace Md.

16 (a) Informant Mary Fretwell
(b) Address Bowie, Md.

17 (a) Burial (b) Date thereof 11/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bowie Catholic Cemetery
Location Bowie Md.

18 (a) Funeral director Martin Gladney
(b) Address Bowie, Md.

19 (a) NOV 13 1947 (Date rec'd by registrar) (b) Huntington-Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1947 at 7:30 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 1947 to 11/13 1947, and that I last saw h[illegible] alive on 11/13 1947.

Immediate cause of death	Duration
Shock responsive to	
Due to Operation for Colostomy	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 11-6-47
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 11-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered; if unknown, write unknown. Be sure to write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write

VS 150

G56918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G56918

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Ave
(c) Hospital or institution: Colonial Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 D
(e) Length of stay in Baltimore (yrs., mos., or days) 28 D

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Sorrento Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret R. Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEM.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1873

8. AGE: Years 74 | Months 10 | Days | If less than one day ____hr. ____min.

9. Birthplace S. Caroline (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Hudson
13. Birthplace IRELAND

MOTHER
14. Maiden Name Mary McESHER
15. Birthplace Boston Mass.

16 (a) Informant Charles E. Hudson (Brother)
(b) Address 5006 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 14-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) 1947 (b) Rec'd by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Nov 1947 at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Sept 1947 to 11 Nov 1947 and that I last saw h[illegible] alive on 7 Nov 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension Cardiovascular Renal Disease	yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emily Royer M.D.

Address 172 Wendover Rd Date signed 11 Nov 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G56919 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 Edmondson Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days) Frederick

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 Edmondson Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT / ANDREWS

3 (b) If veteran, name war: World War No. 1

3 (c) Social Security Account No. 216-03-2069A

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rena C. Andrews

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 29, 1874

8. AGE: Years 73 | Months 0 | Days 18 | If less than one day: hr. min.

9. Birthplace: Caroline Co., Md.
(Town, county, and state)

10. Usual Occupation: Engineer

11. Industry or business: Ward Baking Co.

FATHER
12. Name: Mathew Andrews
13. Birthplace: Caroline Co., Md.

MOTHER
14. Maiden Name: Mary E. ?
15. Birthplace: Caroline Co., Md.

16 (a) Informant: Mrs. Rena C. Andrews
(b) Address: 2509 Edmondson Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/17/47 (month) (day) (year)
(c) Cemetery or crematory: Arlington National Cem.
Location: Arlington, Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 NOV 13 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1947, at 2 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull
Subdural Hemorrhage, Left.

Due to

Other Conditions Cirrhosis of Liver
Generalized arterio-sclerosis
(Indicate pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/12/47 at 2012 10 A.M.
(b) Where did injury occur? 2509 Edmondson Ave Balto MD
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell

23. Signature [signature] M.D.
Medical Examiner
Date signed 11-13-47

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G56920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56920 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3243 Abel Ave P.O.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3243 Abell Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Toronto, Canada

3 (a) FULL NAME William Dean Slater

3 (b) If veteran, name war

3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Eula Margaret Slater (nee Parsons) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	12	hr. min.

9. Birthplace London, Ontario, Canada
(Town, county, and state)

10. Usual Occupation Physician retired

11. Industry or business

FATHER
12. Name William Slater
13. Birthplace London, Ontario, Canada

MOTHER
14. Maiden Name Elizabeth Dean
15. Birthplace London, Ontario, Canada

16 (a) Informant Mrs. Eula M. Slater
(b) Address 3243 Abell Ave.

17 (a) Removal (b) Date thereof 11/13/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Toronto, Canada

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md., U. S. A.

19 (a) NOV 13 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1947, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 11/12/47

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G56921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G56921

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 Towson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Daly

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/11/40

8. AGE: Years	Months	Days	If less than one day
7	-	-	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation School Student
11. Industry or business —

FATHER	12. Name Gilbert Daly
	13. Birthplace Baltimore
MOTHER	14. Maiden Name Loretta Doran
	15. Birthplace Baltimore

16 (a) Informant Loretta Daly
(b) Address 1344 Towson St

17 (a) Burial (b) Date thereof 11/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E. Fort Ave

19 (a) NOV 13 1947 (b) Huntington Williams, M.D.
(Local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1947, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy on and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull with intracranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-9-47 at 4:25 P.M.
(b) Where did injury occur? Fort Ave. & Latrobe Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Ruby struck by auto

23. Signature Carl L. Kreyer, M.D.
Medical Examiner.
Date signed 11-11-47

VS 151

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

656922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓72a

Registered No. 656922

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 81 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 N. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Clara May Cooper

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1896

8. AGE 51 years 8 months 28 days If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business at Home

FATHER
12. Name Anthony Cline
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name — Sweeney
15. Birthplace Baltimore, Md.

16 (a) Informant Raymond E. Cooper
(b) Address 1534 Rosedale St, Baltimore, Md

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cox Inc.
(b) Address 1217 St. Paul St.

NOV 14 1947 (Date rec'd by registrar) (By) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1947 at 2 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1947 to Nov 13 1947, and that I last saw her alive on Nov 12 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Pernicious anemia	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank H. Logan M. D.
Address Hosp. for Women Date signed 11-13-47

56923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

C56923 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Pinewood Ave.
(c) Hospital or institution: 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Pinewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: JOHN W. KAWALSKI

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 220-22-0769

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Lillian Kawalski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 22, 1890

8. AGE: Years	Months	Days	If less than one day
56	10	19	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired Fireman
11. Industry or business

FATHER
12. Name: John Kawalski
13. Birthplace: Germany

MOTHER
14. Maiden Name: August Hendricks
15. Birthplace: Germany

16 (a) Informant: Mrs. Bertha Literski, sister
(b) Address: 3008 Pinewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11.14.47 (month) (day) (year)
(c) Cemetery or crematory: St. Stanislaus Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 NOV 14 1947 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1947, to Nov. 11 1947, and that I last saw him alive on Nov. 10 1947.

Immediate cause of death	Duration
Pulmonary hemorrhage	
Due to Carcinoma of lung	
Due to metastasis of Carcinoma of stomach	
Other Conditions Primary Pernicious Anemia	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Charles D. MacMunn M. D.
Address 2911 E. Balto. St Date signed Nov 13 1947

X

56924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G56924
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St 62
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Boston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10, 1903

8. AGE: Years 44 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Guilford, MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business Laborer

FATHER
12. Name Nicholas Boston
13. Birthplace unknown

MOTHER
14. Maiden Name Margaret [illegible]
15. Birthplace unknown

16 (a) Informant Annie Nelson
(b) Address 813 Pennsylvania Ave

17 (a) Burial (b) Date thereof 11/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Frederick Rd. Balto.

18 (a) Funeral director Metropolitan Funeral Homes
(b) Address 927 N. Mount St

NOV 14 1947 (a) (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/ 1947 at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1947 to 11/10 1947 and that I last saw h[illegible] alive on 11/10 1947

Immediate cause of death Ca. of Liver — Duration 7
Due to 2 Dyspnea
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Primary Ca of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Warner M.D.
Address 1511 Pennsylvania Ave Date signed 11/12/47

X

356925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93E

Registered No. G56925

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1118 Poplar Grove St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 82 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Poplar Grove St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Hoffman

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FM	W	Widowed

6 (b) Name of husband or wife Edward J. Hoffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1863

8. AGE: Years	Months	Days	If less than one day
84	2	10	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

MOTHER | FATHER
12. Name George Myers
13. Birthplace Germany
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Edward F. Hoffman
(b) Address 2907 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 NOV 14 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to Nov 12 1947 and that I last saw h[illegible] alive on Nov 12 1947.

Immediate cause of death: Pulmonary Aedema — Duration: 2 days

Due to Myocardial Insufficiency — 3 mos.

Due to Arteriosclerosis — 5 yrs

Other conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. W. Zimmerman M.D.
Address 2858 Harford Ave. Date signed 11/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

56926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54 B

G56926 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Levindale
(b) Street address Baltimore Ave
(c) Hospital or Institution: Aged Home 1513
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 Oswego Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IDA ZLATIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Jacob

13. Birthplace Russia

MOTHER 14. Maiden Name Rael

15. Birthplace Russia

16 (a) Informant Husband

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Jewish Cem

Location Woodlawn Jewish Cem

18 (a) Funeral director Jewish Funeral Inc

(b) Address 2100 Eutaw Pl

19 NOV 14 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1947 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Octob. 9 1947 to Nov. 14 1947 and that I last saw her alive on Nov. 14 1947

Immediate cause of death Malignant tumor of brain — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Nagel M. D.

Address Levindale Home Date signed Nov. 14 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Every question must be answered. Write correct age in each case. Do not use ditto marks. Be sure to state the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

56927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

839

G56927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26 S. Culver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 S. Culver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary K. Childs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Widow

6 (b) Name of husband Late Horace G. Childs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1875

8. AGE: Years	Months	Days	If less than one day
71	10	27	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Hunbeck
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Geo. T. Childs
(b) Address 265. Culver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 15-'47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3501 Frederick Rd.

18 (a) Funeral director Harry H. Wittee
(b) Address 4101 Edmondson Ave.

NOV 14 1947 (c) (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1947 at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1947 to Nov 12 1947 and that I last saw her alive on Nov 12 '47.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Siocenich M.D.
M. D.
Address 1429 W Fayette Date signed Nov 13 1947

256928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1115 B

Registration No. 256928

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Harlem Ave
(c) Hospital or institution: 162
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Edgar Timmons ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 261-20-2495

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C	M.

6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6-1913

8. AGE: Years	Months	Days	If less than one day
34	2	4	hr. min.

9. Birthplace Jefferson Co. Ga. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Lank Timmons
13. Birthplace Ga.

MOTHER
14. Maiden Name Rosie Hattaham
15. Birthplace Ga.

16 (a) Informant Lewis Timmons
(b) Address 285 Hoyle Terrace N. Walbrook Ave

17 (a) Bl. (Burial, cremation, or removal) (b) Date thereof 11-15-47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Govans Md.

18 (a) Funeral director Samuel N. Sullivan Jr.
(b) Address 1011 N. Arlington Ave.

19 NOV 14 1947 (Date received by local registrar) (b) Huntington Williams M.D.

NVS 150 - 1A1A

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1947 to 11-10 1947 and that I last saw h[illegible] alive on 11-9 1947.

Immediate cause of death	Duration
(a) Acute Myocarditis	10 hr
Due to (b) Streptococcus Sore Throat	5 da
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature B. N. Hatchett M. D.
Address 1725 Pa Ave Date signed 11/14/47

X

G56929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56929 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied as correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26 E Randall St
(c) Hospital or institution: 232
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 E Randall St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George E Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Florence E Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 1870

8. AGE: Years 77 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Smith
13. Birthplace Germany

MOTHER 14. Maiden Name Gent-Patow
15. Birthplace Germany

16 (a) Informant Mrs Elsie M Collins
(b) Address 962 Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto Md

18 (a) Funeral director A Howard Timmons
(b) Address 1400 Cleveland Ave

19 (a) NOV 14 1947 (b) Huntington Williams M.D. Registrar
a = Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1947, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Nov 12 1947 and that I last saw him alive on Wed. Nov 12 1947

Immediate cause of death Cerebral Embolism — Duration

Due to Hypertension Arteriosclerosis Cardiac Failure — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Wm Hamrick

Address 333 E Eager St Date signed 11/14/47

56930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G56930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 S. Essex Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 S. Essex Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob J. Szymkowiak

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-03-3834

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Tina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 7 1889

8. AGE: Years 58 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace: Balto. (Town, county, and state)

10. Usual Occupation:

11. Industry or business: Clerk

FATHER 12. Name: John Szymkowiak
13. Birthplace: Poland

MOTHER 14. Maiden Name: Mary
15. Birthplace: Poland

16 (a) Informant: Mollie Szymkowiak
(b) Address: 1105 S. Essex Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 15 47 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: Garrison Forest Rd

18 (a) Funeral director: Mat. W. & Appel Sons
(b) Address: 37 S. Carey St.

NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1947 at 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Nov. 12 1947 and that I last saw him alive on Nov. 12 1947

Immediate cause of death: Coronary Thrombosis — Duration: days

Due to: Angina Pectoris — 10 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: None
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: J. A. Rosenblatt M. D.

Address: 3018 O'Donnell St. Date signed 11-13-47

G56931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G56931

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison 14
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth C. Hutton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 26, 1880

8. AGE: Years 67 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name W. Parnell Carr

13. Birthplace Maryland

MOTHER 14. Maiden Name Bertie W. Williamson

15. Birthplace Virginia (Norfolk)

16 (a) Informant Mrs. Robert N. Carr

(b) Address 653 Hanover St Riverside

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 NOV 14 1947 (Date rec'd by registrar) (b) Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1947, at 8:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1947 to Nov. 12 1947, and that I last saw her alive on Nov 12 1947

Immediate cause of death Respiratory Failure — Duration

Due to Hypostatic Pneumonia

Due to

Other Conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Burkhart

Address Md. Gen. Hosp. Date signed Nov 12, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

111c

G56932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192C

Registration No. G56932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1050 W Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1050 W Fayette St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Roberts

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Ella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1881

8. AGE: Years	Months	Days	If less than one day
65 66	10	16	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Mary Bonner
15. Birthplace Va

16 (a) Informant James Roberts
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/47 (month) (day) (year)
(c) Cemetery or crematory McCulloh St
Location Balt City

18 (a) Funeral director David J Brown & Son
(b) Address 1618 Montgomery St

NOV 14 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/47 19 , at 1 10 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/10 1945 to 11/10 1947, and that I last saw h alive on 11/10 1947.

Immediate cause of death Edocarditis
Mycocarditis

Duration

Due to
Due to
Other Conditions arthritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature David J Lauder
Address 1226 Lee n Date signed M. 11 D. 12/47

X

C56933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. C56933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Druid Hill Ave.
(c) Hospital or institution: 113
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Pate

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1890

8. AGE: Years: 57 | Months: 6 | Days: 1 | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Viola Pate

(b) Address 413 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) Nov 1947 (Date rec'd by Registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1947, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2, 1947, to Nov 11, 1947, and that I last saw h[illegible] alive on Nov 11 1947

Immediate cause of death: Pneumonia & lobar atelectasis & hiss — Duration: 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Moseley M. D.

Address 70 [illegible] Date signed 11/15/47

X

C56934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered C56934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1841 E. 30th St.
(c) Hospital or institution: 9th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1841 E 30th (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel J. Will Sr.
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-10-8684

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Cecelia Will
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Jan 9, 1882
8. AGE: Years 65 | Months 10 | Days 3 | If less than one day ... hr. ... min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Supt. Dairy
11. Industry or business Retired

FATHER
12. Name Julius Will
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dont Know
15. Birthplace " "

16 (a) Informant Daniel Will Jr.
(b) Address 1841 E 30th St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15th (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City
18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.
19 NOV 14 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1947, at 10 20 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1940 to Nov 12 1947 and that I last saw h... alive on Nov 12 1947

Immediate cause of death: Myocarditis
Due to: Hypertension
Due to: Arteriosclerosis
Other Conditions:

Duration
2 yrs
2 yrs
7 yrs

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Geo. L. Timmerman M. D.
Address 9858 Harford Rd Date signed 11-14-47

VS 150

G56935 D.C. J-91574 BALTIMORE CITY HEALTH DEPARTMENT G56935

CERTIFICATE OF DEATH ✓ 109a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33d Sts.
(c) Hospital or institution: Union Memorial Hosp. 12 hrs
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 mins.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 South Ellwood ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Conrad Swann ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 14 47

8. AGE: Years | Months 1 (one) | Days + | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John W. Swann
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ruth Broise
15. Birthplace Baltimore, Md.

16 (a) Informant John W. Swann
(b) Address 309 S Ellwood Ave

17 (a) Burial (b) Date thereof Nov 17-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Comm
Location City

18 (a) Funeral director Hillsich Funeral Home
(b) Address 2008 Eleanor St

19 (a) NOV 14 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 — 14 1947 at 6:10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 — 13 1947 to 11 — 14 1947 and that I last saw him alive on 11 — 14 1947

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Pneumonia	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James McC. Fenney M. D.
Address Union Memorial Hosp. Date signed 11-14-47

VS 150

X

G56936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. G56936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution: HOSPITAL FOR THE WOMEN OF MARYLAND 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 E 21ST ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME LILLIAN TURNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB ? 1862

8. AGE: Years	Months	Days	If less than one day
85	9	?	hr. min.

9. Birthplace Wycomoco Co. MARYLAND (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business NONE

FATHER
12. Name JOHN TURNER
13. Birthplace Wycomoco Co., MD.

MOTHER
14. Maiden Name CORNELIA ANDERSON
15. Birthplace WYCOMOCO CO. MD

16 (a) Informant CHARLES V. TURNER
(b) Address 325 E. 21ST ST.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 16 47 (month) (day) (year)
(c) Cemetery or crematory Lyons Cem
Location Pantridge Wicomico Md

18 (a) Funeral director C. Megarity
(b) Address Westminster Md

19 (d) NOV 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1947 at 10 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Nov. 1947, to 13 Nov. 1947 and that I last saw her alive on 13 Nov. 1947

Immediate cause of death	Duration
CARDIO RESP. FAILURE	
Due to ARTERIOSCLEROTIC HEART DISEASE	
Due to	
Other Conditions HYPERTROPHIC ARTHRITIS	8 YRS
DIABETES MELLITUS	

(Interval between onset and death)

Date of operation
Major findings of operation:
of autopsy: No in CASE OF DEATH.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Fred B Agnew M. D.
Address Woman's Hosp. Date signed Nov 13, 1947

VS 150

93D

G56937 BC# 1-12180 /107 G56937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure the causes of death clearly and legibly. Give correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 751 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JEAN WRIGHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1947

8. AGE: Years	Months	Days	If less than one day
	8	5	hr. min.

9. Birthplace Baltimore md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Wright
13. Birthplace Florence S. C.

MOTHER
14. Maiden Name Costella Lane
15. Birthplace Lynchburg va

16 (a) Informant Edmonia Lane
(b) Address 751 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1022 Baltimore ave

19 (a) NOV 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1947, at 10.50 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Broncho-pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Voyle M.D.
Medical Examiner.
Date signed 11-12-47

X

G56938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56938 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Report the causes of death clearly and legibly. Use no abbreviations. Give the correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 E. Lombard Street
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Morris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Singer Morris

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Yrs. 53 | Months | Days | If less than one day hr. min.

9. Birthplace Pitt Co. N. C. (Town, county, and state)

10. Usual Occupation Preacher

11. Industry or business

FATHER 12. Name George Henry Morris
13. Birthplace Baxter Co. N. C.

MOTHER 14. Maiden Name Emley Millet
15. Birthplace Pitt Co. N. C.

16 (a) Informant Singer Morris
(b) Address 1515 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16. 1947 (month) (day) (year)
(c) Cemetery or crematory Sweet Hope Cem.
Location Greenville N. C.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1004 Bloomfield Ave

19 (a) NOV 14 1947 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16/47 19 ..., at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Inspection, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. (Medical Examiner.)
Date signed 11/17/47

VS 151

G56939 LW 114490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G56939

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 17-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1217 Myrtle Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Butler Millard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Laura

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May, 11, 1882

8. AGE: Years	Months	Days	If less than one day
65	6	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name David Millard

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Sophie Smallwood

MOTHER 15. Birthplace Md.

16 (a) Informant B.C.H.Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Nov. 17, 1947
(Burial, cremation, or removal) (month, day, year)

(c) Cemetery or crematory Jew Cathedral

Location Baltimore, Maryland

18 (a) Funeral director Mrs. George H. Gelhaus

(b) Address 163 Druid Hill Ave.

19 (a) NOV 14 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1947, at 10:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1947 to Nov. 13 1947, and that I last saw h alive on Nov. 13 1947

Immediate cause of death	Duration
Cardiac Failure	2 hrs.
Due to Hypertension - Heart Disease	years
Due to	
Other Conditions Arteriosclerosis	years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: see above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. E. Robinson Jr.

Address Balt. City Hosp. Date signed 11/13/47
M. D.

G56940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓13la

Registered No. G56940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 N. Fulton Ave.
(c) Hospital or institution: 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lacy Neal

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Ellis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1889

8. AGE: Years 58 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace South Boston, Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick H. Lacy
13. Birthplace Virginia

MOTHER
14. Maiden Name Betty Crawley
15. Birthplace Virginia

16 (a) Informant Mr. Henry Neal
(b) Address 726 N. Fulton Ave.

17 (a) Burial (b) Date thereof Nov. 15, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore, Maryland

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 NOV 14 1947 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12, 1947, at 4:32 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1947, to 11/12 1947, and that I last saw her alive on 11/9 1947

Immediate cause of death: Vascular hypertension, arteriosclerosis, nephritis — Interval between onset and death: Years.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry D. McCarty M. D.
Address 37 W Preston St Date signed 11/13/47

X

G56941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓10W

G56941 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos 20 ds
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 Mosher St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Claude Wooten

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Barbara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1871

8. AGE: Years 76 | Months 6 | Days 3 | If less than one day: hr. min.

9. Birthplace N.C (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Vera White
(b) Address 1906 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location TARBORO, N.C.

18 (a) Funeral director Mun. Lee St. Hall and
(b) Address 1621 Druid Hill Ave

19 (a) NOV 14 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1947 at 9:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18/1946 to 11/12/1947, and that I last saw him alive on 11/12/1947

Immediate cause of death: Cardiac failure — Duration: 4 mos.

Due to: Hypertension — 10 yrs

Due to:

Other Conditions: Fracture of femur tibia & fibula; Fracture of L.H.
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/18/46 at 7:45 P.M
(c) Where did injury occur? York Rd. & Lake Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public Place While at work? ---
(Specify type of place)
(e) Means of injury Pedestrian struck by auto

23. Signature O. W. Hyde M. D.
Address Provident Hospital Date signed 11/12/47

VS 190

G56942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87E

Registered No. G56942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3923 Juniper Rd
(c) Hospital or institution: 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3923 Juniper Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Melissa E. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1936

8. AGE: Years	Months	Days	If less than one day
11	5	11	hr. min.

9. Birthplace Conn.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Dr. Harry B. Smith
13. Birthplace N. Carolina

MOTHER 14. Maiden Name Isabel B. Smith
15. Birthplace Conn.

16 (a) Informant Dr. Harry B. Smith
(b) Address 3923 Juniper Rd

17 (a) Burial (b) Date thereof 11-15-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Palisado Cem.
Location Windsor Conn.

18 (a) Funeral director John G. Moran
(b) Address 3000 E. Balt. St.

19 (a) NOV 14 1947 (b) Huntington Williams, M.D.
(Local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to 11/13 1947 and that I last saw her alive on 11/13 1947.

Immediate cause of death: Bronchopneumonia — Duration 3 da.

Due to

Due to

Other Conditions: Cerebral Palsy. Cerebral degenerative disease. — Duration Birth
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson Smith M. D.
Address 4 E 33rd St Date signed 11/14/47

VS 150

107

G56943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G56943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2520 N. Hilton St.
(c) Hospital or institution: Asbuton Home 20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore City. (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Holly St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Smith.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widowed

6 (b) Name of husband or wife. Henry A.
6 (c) If alive, give age S. years

7. Birth date of deceased (mo., day, yr.) April 26. 1861

8. AGE: Years	Months	Days	If less than one day
86	6	22½	— hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business " "

FATHER
12. Name Peter Quinn
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ann Jamison
15. Birthplace Ireland.

16 (a) Informant Mr. Louis Rapp
(b) Address 211 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 15 Nov. 47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director F. B. Hilbert & Son
(b) Address 1300 Eutaw Place.

19 (a) NOV 14 1947 (Date rec'd by Registrar) Interment for Williamsport

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1947 at 1-A.M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 3 1947 to NOV 12 1947 and that I last saw her alive on NOV 11 1947

Immediate cause of death Bronchial pneumonia — Duration 8 days

Due to

Due to Bronchopneumonia — 8 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter Hilbert M. D.
Address 2220 Garrison Blvd Date signed

X Nov 13/47

G56944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Chapelgate Lane
(c) Hospital or institution: Pinecrest Sanitarium 25.1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 S. Chapelgate Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie E. Beck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1872

8. AGE: Years	Months	Days	If less than one day
75	7	19	hr. min.

9. Birthplace Brooklyn, N. Y.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Bernard J. Beck
13. Birthplace Baltimore

MOTHER
14. Maiden Name Minnie S. Vollmer
15. Birthplace Brookly, N. Y.

16 (a) Informant Adele Kirby
(b) Address 14040 Franklin Ave., Flushing

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 14- (month) (day) (year)

(c) Cemetery or crematory
Location New York, N. Y.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 14 1937 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1937, at 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1937, to Nov 13 1937, and that I last saw he alive on Nov 12 1937.

Immediate cause of death	Duration
Arteriosclerotic C-V-D	
Due to	
Due to	
Other Conditions Edinburgh	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Arthur Rosaberg M. D.

Address 600 S. Chapel Gate La. Date signed 11/18/1937

VS 180

G56945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 S. Payson St.
(c) Hospital or institution: 20-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 S. Payson St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William G. Elderkin

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-5266

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irene

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Dec. 3-1859

8. AGE: Years 87 | Months 11 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name James K. Elderkin
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah E.W. Conrad
15. Birthplace Waterford Va.

16 (a) Informant Mrs. Irene P. Elderkin
(b) Address 329 S Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 15 Nov 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director C. Blickhart & Son
(b) Address 1700 Eutaw Place

19 (a) NOV 14 1947 (Date rec'd by registrar) (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1947 at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Nov. 12 1947 and that I last saw living alive on Nov. 12 1947

Immediate cause of death: arteriosclerotic cardio-vascular disease — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Vernon Williamson M. D.
Address 4508 Edmondson Village Date signed 11/13/47

G56946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 83a

Register No. G56946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens Ave.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore County

(c) City or town Baltimore #28 (If outside city or town limits, write RURAL and give town)

(d) Street No. 127 Oakdale Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Carrie Cadogan

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James B. Cadogan

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1870

8. AGE: Years: 77 Months: 6 Days: 17 If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER

12. Name: Christian Poellmann

13. Birthplace: Maryland

MOTHER

14. Maiden Name: Louisa Gassell

15. Birthplace: Maryland

16 (a) Informant: Mrs. Agnes C. Jamison

(b) Address: 127 Oakdale Ave Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1947 (month) (day) (year)

(c) Cemetery or crematory: Salem Lutheran

Location: Ingleside Ave Catonsville

18 (a) Funeral director: Eastons Sons

(b) Address: 618 Fredericks Ave Catonsville

19 (a) NOV 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12, 1947, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1947, to Nov. 12 1947, and that I last saw alive on Nov. 12 1947

Immediate cause of death	Duration
Intracerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Jose L. Feldman M. D.

Address St. Agnes Hosp. Date signed Nov 12 '47

VS 150

X

G56947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56947 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Use "None" where necessary. If unknown, supply approximate date. Do not abbreviate. Write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2558 W Balto St
(c) Hospital or institution: 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits write RURAL and give town)
(d) Street No. 2558 W Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence M. Snyder

3 (b) If veteran, name war	3 (c) Social Security Account No. 220-07-2012

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Anna Snyder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1890

8. AGE: Years	Months	Days	If less than one day
XXXX 57	7	24	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Empire Nursery Prod. Co. Newark, N. J.

FATHER
12. Name James H. Snyder
13. Birthplace Conn.

MOTHER
14. Maiden Name Etta B. Ging
15. Birthplace Auburn, N.Y.

16 (a) Informant Mrs. Bessie S. Thompson
(b) Address Mt. Pleasant Beach, Pasadena P.O.

17 (a) Burial (b) Date thereof 11/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 14 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1947 at 1:40 A.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 11/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C56948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. C56948

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland Gen. Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 569 E. 38 D Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Clara Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Stewart Little

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 16 1890

8. AGE: Years 57 | Months 3 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Joseph H. Spicer
13. Birthplace Delaware

MOTHER
14. Maiden Name Lottie M. Hunkavon
15. Birthplace Delaware

16 (a) Informant Mr. Stewart Little
(b) Address 569 E. 38 D Street. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-1947 (month) (day) (year)
(c) Cemetery or crematory Georgetown
Location Georgetown Delaware

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) NOV 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1947, at 6:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1947, to 11-13 1947, and that I last saw h~~e~~r alive on 11-12 1947

Immediate cause of death	Duration
Septicemia	
Due to abscess from rectum through buttock in the st.	
Due to Ca. of rectum	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy: Ca of rectum abscess from rectum through buttock

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature Richard G. Martin M. D.
Address Md. Gen. Hosp. Date signed 11-13-47

VS 150

G56949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G56949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie Latney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-2-06

8. AGE: Years 41 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Doctor Garland
13. Birthplace Va

MOTHER 14. Maiden Name Mary Berle
15. Birthplace Va

16 (a) Informant Records
(b) Address

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 11-14-47 (month) (day) (year)
(c) Cemetery or crematory Gloucester Co.
Location Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 NOV 14 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1947, at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 19 47 to Nov 11 19 47 and that I last saw her alive on Nov 11 19 47.

	Duration
Immediate cause of death Uremia	3 months
Due to Chronic nephritis	
Due to arteriosclerotic	
Other Conditions Hypertensive cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Grob M. D.
Address 3-H-H Date signed 11 Nov 47

VS 150

G56950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G56950

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2145 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2145 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME William Thomas Zepp.

3 (b) If veteran, name war: None.
3 (c) Social Security Account No. 220-09-0909A

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie Theresa Zepp
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 26, 1871

8. AGE: Years 76 | Months 6 | Days 18 | If less than one day: hr. 17 min.

9. Birthplace: Baltimore, Maryland. (Town, county and state)
10. Usual Occupation: Stencil Cutter
11. Industry or business: Balto. Enamel & Porcelain Co.

FATHER
12. Name: Charles Zepp.
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Dora Mitchell
15. Birthplace: Maryland.

16 (a) Informant: Marie T. Zepp.
(b) Address: 2145 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-47 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore, Maryland.

18 (a) Funeral director: George L. Pethurel
(b) Address: 2101 W. Frederick Avenue

(Date received by Registrar) Huntingtown, Williams, Md.
NOV 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1947, at 945 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1947 to 11/13 1947, and that I last saw him alive on 11/13 1947

Immediate cause of death: Bronchopneumonia — Duration: 4 days.
Due to:
Due to:
Other Conditions: Old Healed Pulmonary Tuberculosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Chas A Zepp M.D.
Address: 2145 W Balto St. Date signed: 11/13/47

NOV 15 1947

G56951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56951 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-7-6
(e) Length of stay in Baltimore (yrs., mos., or days) 27-7-6

2. USUAL RESIDENCE OF DECEASED:
(a) State Connecticut (b) County
(c) City or town Waterbury (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 Charles Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Reverend James R. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (May) 1879

8. AGE: Years	Months	Days	If less than one day
68 ~~years~~	6 ~~months~~	3 ~~days~~	hr. min.

9. Birthplace Waterbury, Connecticut (Town, county, and state)

10. Usual Occupation Catholic Priest

11. Industry or business

FATHER
12. Name Stephen Mitchell
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Russell
15. Birthplace Ireland

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Road, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-1947 (month) (day) (year)
(c) Cemetery or crematory All St. Josephs.
Location Waterbury - Conn.

18 (a) Funeral director Stewart & Mowan Co.
(b) Address 106 West North Ave. Balto. Md.

19 NOV 15 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1947, at 2:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1930, to Nov. 14 1947, and that I last saw him alive on Nov. 14, 1947.

Immediate cause of death Coronary occlusion — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State).
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond P. Alegia M. D.

Address 336 Fairfield Ave. Date signed

G56952 B-32458 BALTIMORE CITY HEALTH DEPARTMENT G56952
CERTIFICATE OF DEATH 104a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 W. Dover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA LEE BEYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1947

8. AGE: Years | Months: 4 | Days: 20 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Henry Beyer
13. Birthplace Maryland

MOTHER
14. Maiden Name Agnes Wright
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Agnes Beyer
(b) Address 1810 W. Dover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Jos. D. Bradley
(b) Address Fayette & Fulton

19 (a) NOV 15 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1947 at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH Upper respiratory infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 11-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as accurately as possible. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age if especially important.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

56953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G56953
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 835 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 835 Light St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Jane Young

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: James W.

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1859

8. AGE: Years 88 | Months 9 | Days 27 | If less than one day ___ hr. ___ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Eliad Simmons
13. Birthplace Md

MOTHER
14. Maiden Name Mary Feeney
15. Birthplace Md

16 (a) Informant Marie E. Young
(b) Address 835 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or crematory Central Church
Location Calvert County, Md

18 (a) Funeral director John F. Kenny Inc
(b) Address 716 Light St

19 NOV 15 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1947, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1947 to Nov 12 1947 and that I last saw her alive on 11/12 1947.

Immediate cause of death	Duration
Arterio-Sclerotic heart disease complicated with general arterio sclerosis	2
Due to —	
Due to —	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Wallace
Address 126 Hanover St Date signed 11/17/47

VS 150

356954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G56954 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4018 Woodridge Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 4018 Woodridge Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucie B Nussbaum

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Harry R
6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Sept 21, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	22	hr. min.

9. Birthplace: Security, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

MOTHER | FATHER
12. Name: Martin L Unger
13. Birthplace: Waynesboro, Penna.
14. Maiden Name: Mary N Fouke
15. Birthplace: Shepherdstown, W. Va.

16 (a) Informant: Harry R Nussbaum
(b) Address: 4018 Woodridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17, 1947 (month) (day) (year)
(c) Cemetery or crematory: Mt Olive, Frederick Md
Location: Frederick, Md.

18 (a) Funeral director: Wm Cook Inc
(b) Address: 1217 St Paul St., Balto

19 (a) NOV 15 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1942 to Nov 13 1947. and that I last saw h alive on Nov 13 1947.

Immediate cause of death: Chronic myocarditis — Duration: 2 months

Due to

Due to

Other Conditions: Cerebral Hemorrhage — Duration: 2 months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lt. Zelly M D M. D.
Address 3517 Edmondson Ave Date signed Nov 14 1947

X

56955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. G56955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not guess at anything. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 Deepdene Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Deepdene Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter G. Schwab

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-10-5865

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Hulda Schwab

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22 1879

8. AGE: Years 68 | Months 5 | Days 12 | If less than one day 23 hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business U. S. Post Office

FATHER
12. Name Reinhold Schwab
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Mehlig
15. Birthplace Germany

16 (a) Informant Charlotte L. Lee
(b) Address 629 Deepdene Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Wm. Cook Sons Inc.
(b) Address 1217 St. Paul St.

19. NOV 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14, 1947, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947, to Nov 1947 and that I last saw him alive on Nov 14 1947.

Immediate cause of death	Duration
Rheumatic Cardio-Vascular	
Due to disease -	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William G. Helfrich M. D.
Address 506 Roland Ave Date signed Nov 16 '47

656956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

G56956
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Forge ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gladys

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-24-07

8. AGE: Years 40 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Plasterer

11. Industry or Business

FATHER 12. Name George Smith

13. Birthplace

MOTHER 14. Maiden Name Anne N. Woolington

15. Birthplace

16 (a) Informant Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 17 47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Frank H. Early

(b) Address 854 N. 36 St

19 NOV 15 1947 (Date rec'd by Registrar) (b) Huntington Mills

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1947 at 5 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1947 to Nov 13 1947, and that I last saw him alive on Nov. 13 1947

Immediate cause of death: BRONCHIAL ASTHMA — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thelma D. Stephens M. D.

Address Johns Hopkins Hosp Date signed 11/14/47

VS 150

G56957 Grave #12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G56957

1. PLACE OF DEATH: Found drowned- E. Falls Ave. &Lancaster Sts.
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass (b) County
(c) City or town Boston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6- Moon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTON JURGELIANTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 50? Months Days If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY NOV 13 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 15 1947 (Date filed by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

p

20. DATE OF DEATH Oct. 16, 1947, at 12.30 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-16-47 at 3/2 12. p. M.
(b) Where did injury occur? Found E Falls and Lancaster Balto Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Found drowned Merrill M.D.
Medical Examiner.
Date signed 10/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G56958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josiah's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 2037 Ellsworth ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas BATEMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-0282

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise Bateman

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Jan-14-1879

8. AGE: Years 68 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired - Meat Cutter

11. Industry or business A & P. Stores

FATHER
12. Name Hudson Bateman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Standiford
15. Birthplace Harford Co. Md.

16 (a) Informant Louise Bateman
(b) Address 2037 Ellsworth Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-47 (month) (day) (year)
(c) Cemetery or crematory Upton Chapel
Location Harford Co. Md.

18 (a) Funeral director John C. Melly Inc
(b) Address 2435 E. Oliver Pl

19 NOV 15 1947 (Date received by Registrar) Huntington-Williams, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1947 at 3:30 PM

21. I certify that I took charge of the remains described above, held an Inspection and Exam thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Geo. L. Merrill M.D.
Medical Examiner.
Date signed 11/14/47

The C56959 114448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. C56959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5316 Denmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Randall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25- 1868

8. AGE: Years	Months	Days	If less than one day
78	10	19	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Peter Randall
13. Birthplace Virginia

MOTHER
14. Maiden Name Mandy Halliman
15 Birthplace Maryland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Gainesville, P. W. Co., Va.

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 NOV 15 1947 Huntington Matthews, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1947, at 10:17 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1947 to Nov. 13 1947, and that I last saw h im alive on Nov. 13 1947.

Immediate cause of death Acute cardiac failure — Duration 1½ hrs

Due to

Due to

Other Conditions post op. supra-pubic prostatectomy — 14d

(Include pregnancy within 3 months of death)

Date of operation 10/30/47

Major findings of operation: Complete prostatectomy

of autopsy: Dr. Snyder and consent

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jordan Craft M. D.
Address Balt. City Hosps Date signed 11/14/47

V S 150

G56960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G56960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1065 Myrtle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MABEL (VIOLA) WALKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-11-1910

8. AGE: Years 37 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Manning S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Richard Dinkins

13. Birthplace S C

MOTHER 14. Maiden Name Mary Green

15. Birthplace S C

16 (a) Informant Mrs Mary Johnson

(b) Address Manning S. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-47 (month) (day) (year)

(c) Cemetery or crematory

Location Manning, South Carolina

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 NOV 15 1947 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1947, at 12.20 P M

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diabetes mellitus

Diabetic coma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 11-13-47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56961
AB-115147

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered G56961 1252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3545 Hanover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Matthews

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 2-1909

8. AGE: Years	Months	Days	If less than one day
38	2	10	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Owen Matthews (D
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Margaret Flynn
15. Birthplace Pennsylvania

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11 15 47
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Plymouth, Luzerne Co Pa
Location Luzerne Co Pa

18 (a) Funeral director Williams Funeral Home
(b) Address 12967 Main St Williamsport, Md

19 NOV 15 1947 Harrington Williams, M.D.
(Date received by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12- 1947, at 8.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11- 1947 to 11-12 1947, and that I last saw h im alive on 11-12- 1947

Immediate cause of death Acute Hepatitis, cause unknown — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Farber M. D.
Address Balto City Hosps Date signed 11-15-47

X

B.C.
G56962 A-58896

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

Registered No. G56962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620- Madison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BARBARA GALE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1942

8. AGE: Years	Months	Days	If less than one day
5	2	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Reginald Gale
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Thelma E. Robinson
15. Birthplace Baltimore, Md.

16 (a) Informant Thelma Gale
(b) Address 1620 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) NOV 15 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1947, at 10 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. (Medical Examiner.)
Date signed 11-14-47

G56963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 630 W. Barre Street.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 630 W. Barre Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM REYNOLDS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1888.

8. AGE: Years	Months	Days	If less than one day
59	10	10	hr. min.

9. Birthplace Eastern Shore, Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Reynolds
13. Birthplace Virginia

MOTHER
14. Maiden Name ?
15. Birthplace Virginia

16 (a) Informant Ruth Curtis
(b) Address 631 Dover Ste.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) 3727 W. Fayette St

19 (a) NOV 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1947, at 8 p. M

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryan M.D. Medical Examiner.
Date signed 11-12-47

G56964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G56964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 E. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James W. Garner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-29-1895

8. AGE: Years 52 | Months 2 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Washington D.C (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business mutual Chemical Co

FATHER
12. Name Joseph Garner
13. Birthplace Washington D.C

MOTHER
14. Maiden Name Ida Frances
15. Birthplace Washington D.C

16 (a) Informant Eva Garner
(b) Address 1518 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. County Md

18 (a) Funeral director Wm. Robt. Elliott & Bro.
(b) Address 1129 N. Caroline St

19 (a) NOV 19 1947 (Date rec'd by Registrar) (b) Transcription from Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 1947, at 3 p.m. 45

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1947 to 11-11 1947 and that I last saw him alive on 11-11 1947

Immediate cause of death: Pulmonary Carcinoma (extra-bronchial) — Duration: approx 1 yr.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: Oct 47

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature K. Brunner M. D.

Address 1500 E. Madison St Date signed 11-13-47

Rayner Brunner X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56965

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 446 N. Linwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 446 N. Linwood Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES DOBIHAL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of ~~husband~~ or wife Josephine (nee Chalone)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/18/1872

8. AGE: Years	Months	Days	If less than one day
75	1	24	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Alois Dobihal
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Until
15. Birthplace Czechoslovakia

16 (a) Informant Mr. Edward Dobihal - son
(b) Address 3801 Fleetwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) NOV 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12/47 19 , at 10:30h M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Nov. 12 1947 and that I last saw him alive on 11/9/47 19

Immediate cause of death	Duration
Congestive Heart Failure	3 yrs.
Due to Hypertension	4 yrs.
Due to	
Other Conditions Arteriosclerosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence M. Leon M.D.
Address 11 E. Chase St Date signed 11/13/47

X

C.O.#

056966 4-9045-T

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G56966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N. Chester Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH L. STEIN.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single.

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1947.

8. AGE: Years: — | Months: 1 | Days: 19 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Herman Stein
13. Birthplace Balto. Md.
14. Maiden Name Louise (SMRHA)
15. Birthplace Balto. Md.

16 (a) Informant Parents
(b) Address 905 N. Chester Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Road

18 (a) Funeral director C. E. SCHIMUNEK.
(b) Address 2641-3-5 E. MADISON ST.

19 (a) NOV 15 1947 (Date rec'd by registrar) (b) Huntington Williams Mt

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1947, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1947 to 11/14, 1947 and that I last saw h.. alive on 11/14 1947.

Immediate cause of death Respiratory failure — Duration:

Due to Atelectasis, left upper and lower lobes.

Due to

Other Conditions Congenital heart disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Atelectasis; cong. heart dis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley N. Sternberg
Address Sinai Hospital Date signed 11/15/47

VS 150

161a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

656967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192a

Registered No. 656967

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 Gorsuch St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Gorsuch St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Reisler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sylvester Reisler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/6/1872

8. AGE: Years 75 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Germany
(Town, County, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Frederick Reisler
(b) Address 1424 Gorsuch St.

17 (a) Burial (b) Date thereof 11/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto. Co.

18 (a) Funeral director Charles F. Hill
(b) Address 1501 E. Fort Ave.

19 NOV 15 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1947, at 4:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1947 to 11/12 1947 and that I last saw he alive on 11/12 1947.

Immediate cause of death Bronchopneumonia following influenza — Duration 5 days

Due to — —

Due to — —

Other Conditions Chronic aortic regurgitation of heart — 2
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Levitsel, M.D.
Address 1326 Harwood St Date signed 11/14/47

VS 150

35a

G56968 BALTIMORE CITY HEALTH DEPARTMENT G56968
CERTIFICATE OF DEATH 131a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 W. Strathmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 W. Strahhmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George I. Daneker

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Martha W /
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1857

8. AGE: Years 90 | Months | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Bank Clerk

11. Industry or business

FATHER
12. Name O. A. Daneker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mariah Lee
15. Birthplace Md.

16 (a) Informant Mrs. Clara Wells
(b) Address 3301 W. Strathmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & PA. Aves.

NOV 16 1947 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/ 14/ 19 47 at 3;30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1940 to Nov 13 1947 and that I last saw him alive on Nov 13 1947

	Duration
Immediate cause of death Terminal Bronchial Pneumonia	1day
Due to Cardiac Renal Vascular Disease	10yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Wilson
Address 614 W 40th St Date signed 11/17/1947 M.D.

V S 150

G56969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G56969 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2203 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE C. STINNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife John H. Stinner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1866

8. AGE: Years	Months	Days	If less than one day
81	5	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Meyer
13. Birthplace Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace "

16 (a) Informant Mrs. James R. Woolmer, daughter
(b) Address 2203 Mt. Holly St.

17 (a) Burial (b) Date thereof 11.17.47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Washington Williams, M.D.
(Date received by registrar) Registrar

NOV 16 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1947 to Nov 14 1947 and that I last saw h[illegible] alive on Nov. 2. 1947.

Immediate cause of death Coronary Occlusion — Duration 1/2 hr.
Due to Hypertensive Heart Disease & Auricular Fibrillation
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 334 Frederick Ave Date signed 11-14-47

G56970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V140B

G56970

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John William Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years 31 | Months | Days | If less than one day hr. min.

9. Birthplace Robinson Co. N. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name F. D. Davis
13. Birthplace Robinson Co. N.C.

MOTHER
14. Maiden Name Mattie Bowie
15. Birthplace Robinson Co. N.C.

16 (a) Informant John William Davis
(b) Address 1905 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)

(c) Cemetery or crematory
Location Bowie N. C.

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brant St

19 (a) (Date rec'd by registrar) (b) Signature of Registrar

NOV 16 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 47 at 8 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Peritonitis

Due to Incomplete abortion

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 11/14/47

G56971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G56971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3507 Dennlyn Road
(c) Hospital or institution: 15 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 Dennlyn Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Shear

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Hyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1892

8. AGE: Years	Months	Days	If less than one day
55	1	4	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Abraham Bard
13. Birthplace Russia

MOTHER
14. Maiden Name Katie ?
15. Birthplace Russia

16 (a) Informant Hyman Shear
(b) Address 3507 Dennlyn Road

17 (a) Burial (b) Date thereof Nov 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Hamilton Ave Rosedale Cem

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

Nov 16 1947 (b)
(Date rec'd by registrar) Registrar

V S 190 Huntington Williams, M.D.

MEDICAL CERTIFICATION 2.45

20. DATE OF DEATH November 14 1947, at p. m.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to 11/14 1947 and that I last saw h[er] alive on Nov 14 1947.

Immediate cause of death	Duration
Acute Coronal Thrombosis	
Due to Hemorrhage	
Due to Arteriosclerosis	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at m
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Augusta St Date signed 11/15/47

8:3a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56972 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3030 Kenyon ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~2 days~~
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Kenyon ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida May Boyd

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife J. Wm Boyd

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Apr 9 1866

8. AGE: Years 81 | Months 7 | Days 7 | If less than one day hr. min. 90

9. Birthplace Rocks, Harford Co Md.
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business at Home

FATHER
12. Name James Monroe Tracey
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Ella Fletcher
15. Birthplace St Paul Harford Co Md

16 (a) Informant Wm Boyd
(b) Address 3030 Kenyon ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19-47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Baltimore Md.

18 (a) Funeral director Martin & Klutz
(b) Address 1200 Eutaw St Baltimore, Md

19 (a) (b)
(Date filed by registrar) Registrar

NOV 16 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1947 at 1130 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1947 to Nov. 16 1947. and that I last saw I.B. alive on Nov 16 1947.

Immediate cause of death Cerebral Thrombosis — Duration
Due to Arteriosclerosis
Due to
Other Conditions Febroids Tumor Suffered for past 7 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of Injury

23. Signature Walter A Anderson M. D.
Address 300 Eastern Ave Date signed Nov. 16-47

+

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓463

G56973 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1922 Cecil Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 CECIL AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL ANDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-2238

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife FLORENCE
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) MAY 20, 1873

8. AGE: Years	Months	Days	If less than one day
74	5	24	hr. min.

9. Birthplace NORWAY
(Town, county, and state)
10. Usual Occupation THEATRICAL
11. Industry or business SELF

FATHER
12. Name ANDREW ANDERSON
13. Birthplace NORWAY

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant MRS. FLORENCE ANDERSON
(b) Address 1922 CECIL AVE

17 (a) Removal (b) Date thereof 11/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery N. Wilkaboro
Location North Carolina

18 (a) Funeral director Williams Cook Inc.
(b) Address 127 St. Paul St

19 (a) Filed (b) Registrar Huntington Williams M.D.
NOV 16 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947, to Nov 14 1947, and that I last saw him alive on Nov 1 1947.

Immediate cause of death	Duration
Carcinoma of Stomach	3 mos.
Due to	
Due to	
Other Conditions Anterior Chronic generalized	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard N. Tillman M. D.
Address 3035 St. Paul St Date signed Nov 14 1947

X

G56974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G56974 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15da.
(e) Length of stay in Baltimore (yrs., mos., or days) 15da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Baltimore Joppa
(If outside city or town limits, write R.F.D. and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Franc M. Holter

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Barbara W. Holter

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Apr. 6, 1904

8. AGE: Years 43 Months 7 Days 8 If less than one day ____ hr. ____ min.

9. Birthplace Joppa, Harford Co. Md (Town, county, and state)

10. Usual Occupation Brick Layer

11. Industry or business

FATHER
12. Name Henry C. Holter
13. Birthplace New Hudson Pa.

MOTHER
14. Maiden Name Theresa M. Pierce
15. Birthplace Joppa Harford Co. Md

16 (a) Informant Mrs. Barbara W. Holter
(b) Address Joppa, Harford Co. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Stephens
Location Bradshaw Maryland

18 (a) Funeral director Howard K. McCormick
(b) Address Abingdon Md

19 (a) (Date rec'd by registrar) Nov 20 1947 Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1947, at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 19__, to Nov. 14 1947, and that I last saw h.i.M. alive on Nov. 14 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Galbreath M. D.
Address Univ. Hosp., Balt. Date signed 11-14-47

X

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1477

G56975 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4815 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4815 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lorenzo Lo Presti

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband~~ wife Carmela
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1885

8. AGE: Years 62 | Months 5 | Days 7 | If less than one day: hr. min.

9. Birthplace Riposto Italy
(Town, county, and state)

10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name Antonio Lo Presti
13. Birthplace Riposto Italy

MOTHER
14. Maiden Name ~~Venera~~ VALASTRO
15. Birthplace Riposto Italy

16 (a) Informant Carmela Lo Presti (Wife)
(b) Address 4815 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Dalba Sons
(b) Address 52 N. Morley St.

19 (a) NOV 16 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1947 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July X 1947 to Nov 13 1947 and that I last saw ~~him~~ her alive on Nov. 12 1947.

Immediate cause of death: Carcinoma of Lung — Duration: 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Dawyer M.D.
Address 4808 Harford Rd. Date signed 11/16/47

VS 150

G56976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G56976
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 Pascal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME COSMOS DOLAN ALTHER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Fannie Sheldon.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 27, 1891

8. AGE: Years: 56 | Months: 11 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Martinsburg, W. Va (Town, county and state)

10. Usual Occupation: Painter
11. Industry or business: Balt. Shipyard

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name: Martha V. Shank
15. Birthplace: Va.

16 (a) Informant: Family
(b) Address: 3823 Pascal St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof: 11-19-47 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Martinsburg, W. Va.

18 (a) Funeral director: Samuel L. McCauley
(b) Address: 130 E. Hoffman

NOV 16 1947 (Date rec'd by registrar)
(b) Huntington Williams Mortuary

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1947, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractures of jaw, ribs, and both tibiae and fibulae.
Due to: Lacerated right lung.
Ruptured left kidney.
Other Conditions: Alcoholism (acute)

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: 11/14/47 at 23 P.M.
(b) Where did injury occur? Pickman & Hanover
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian struck by auto

23. Signature: George L. Merrill M.D.
Medical Examiner.
Date signed: 11/15/47

G56977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

Registered No. G56977

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the exact causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 Chapel Gate Lane
(c) Hospital or institution: Ventnor Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3905 Hanover St
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME James M. Brannan Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife Elizabeth C. Brannan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7- 1893

8. AGE: Years 54 | Months 3 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Tavern Keeper
11. Industry or business

FATHER
12. Name Thomas Brannan
13. Birthplace

MOTHER
14. Maiden Name Mary Jelwick
15. Birthplace Ireland

16 (a) Informant Elizabeth C. Brannan
(b) Address 3905 Hanover St

17 (a) Burial (b) Date thereof Nov. 18- 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director Milton Schelling
(b) Address 3914 Hanover St-25-

19 Nov 16 1947 (b)
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1947 at 11. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14/47 19 to 11/14/47 19, and that I last saw h[illegible] alive on 11/14/47 19.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Disease	
Due to Cardiac Decompensation	
Due to	
Other Conditions Syphilis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton Tonsley M. D.
Address 2444 Wash. Blvd. Date signed 11/15/47

Huntington Williams M.D.

937

G56978 / BALTIMORE CITY HEALTH DEPARTMENT / G56978

CERTIFICATE OF DEATH

212 / 74a / Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 W. Belair Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sandra Goff (GROFF)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/5/43

8. AGE: Years 4 | Months 7 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Mich.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Goff
13. Birthplace Mich.

MOTHER
14. Maiden Name Marilyn Hartsock
15. Birthplace Mich.

16 (a) Informant Charles Groff
(b) Address 644 W Belair Ave. Aberdeen Md

17 (a) Removal (b) Date thereof 11-16-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Kalamazoo Mich

18 (a) Funeral director Henry Tarking Son
(b) Address Aberdeen Md

19 (a) 11-19-47 (Date rec'd by registrar) (b) Clinton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1947, at 5:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1947, to 11/16 1947, and that I last saw her alive on 11/16 1947

Immediate cause of death	Duration
LEUKEMIA, lymphatic = leukemic infiltration of intestinal wall mainly in cecal region	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy (all findings not complete)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John S. Morris M. D.
Address Johns Hopkins Hosp. Date signed 16 Nov 47

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 130

G56979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56979

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 Linnard St.
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Linnard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Grace Kimmel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14 1867

8. AGE: Years	Months	Days	If less than one day
80	5	2 1	hr. min.

9. Birthplace Grafton W Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Kimmel
13. Birthplace Evansville W Va.

MOTHER
14. Maiden Name Hannretta Carington
15. Birthplace Winchester Va.

16 (a) Informant Mrs Cecil K. Harrison
(b) Address 713 Linnard St. Balto. 29 Md.

17 (a) Removal (b) Date thereof Nov. 16-1937
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bluemont
Location Grafton W Va.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania

NOV 17 1937

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1937, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1937, to Nov 15 1937, and that I last saw h-d alive on Nov 11 1937.

	Duration
Immediate cause of death Cardiac Stasis	6 D.
Due to Cardio Vascular disease.	8 Yr.
Due to Myocarditis	1 Yr.
Due to Influenza.	8 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature Edw Loomis M.D.
Address 1202 S. Paca St Date signed 11/16/37 M. D.

X

G56980 Vrchotice

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G56980

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 N. Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH Svoboda (SVOBADA)

3 (b) If veteran, name war: Spanish-American
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife: Mamie Svoboda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1881

8. AGE: Years	Months	Days	If less than one day
66	6	21	hr. min.

9. Birthplace: Bechor-Slovakia (Town, county, and state)
10. Usual Occupation: Tailor
11. Industry or business

FATHER
12. Name: James Svoboda
13. Birthplace: Czechoslovakia

MOTHER
14. Maiden Name: Josephine Berney
15. Birthplace: Czechoslovakia

16 (a) Informant: Joseph Svobod Jr
(b) Address: 2036 Gough st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balt Md

18 (a) Funeral director: Frank Croach Son
(b) Address: 900 N. Chester st.

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1947, at 5:40 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Rupture of Liver
Compound Fractures Rt. tibia & fibula
Fract. Rt. Humerus, Rt. Clavicle,
Due to Rt. 2-9 Ribs -

Other Conditions Generalized Arterio-sclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-11-47 at 4:30 P. M. 4/1
(b) Where did injury occur? 200 Blk. Pratt Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto-hit & run

23. Signature Earl K. Royer M.D.
Medical Examiner.
Date signed 11-14-47

Huntington Williams M.D.

056981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 87E

Registered No. 056981

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 McElderry Street
(c) Hospital or institution: None 7-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 McElderry Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - -

3 (a) **FULL NAME** PAUL BAUM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 11, 1918

8. AGE: Years	Months	Days	If less than one day
28	11	4 3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name James Baum
13. Birthplace ?

MOTHER
14. Maiden Name Cecelia Zinkand
15. Birthplace ?

16 (a) Informant James A. Baum (father)
(b) Address 3002 MCElderry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road, Baltimore

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe Street

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) [signature] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1947, at 5:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1947, to Nov 14 1947, and that I last saw him alive on Nov 14 1947.

Immediate cause of death	Duration
Acute Anaemia	2 days
Due to Acute Nephritis	11 days
Due to	
Other Conditions Puerperal Abortus Paraphegia (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 700 N. Patterson Pk. Date signed 11/15/47

120

G56982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G56982

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4026 W Rogers Ave. 27-19
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4026 W Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adolph Ebeler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katherine Ebeler

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 28 (18[illegible])

8. AGE: Years	Months	Days	If less than one day
27 (58)	7	17	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Ernest Ebeler
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Rinkrose
15. Birthplace Germany

16 (a) Informant Katherine Ebeler
(b) Address 4026 N Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19-47 (month) (day) (year)
(c) Cemetery or crematory St Pauls Cem
Location Druid Hill Park

18 (a) Funeral director Mrs Chas A. J Rohde
(b) Address 2327 Edmondson Ave

19 (a) NOV 17 1947 (Date recd by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19[illegible] to 19[illegible], and that I last saw h[illegible] alive on 19[illegible].

Duration

Immediate cause of death Coronary occlusion — 5 Months
(see other side)
Antecedent —
Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Howard L. Wagley M.D.
Address 3900 Alameda Blvd Date signed Nov 17 1947

G56983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G56983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 263 Dol

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dol
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3040 Chesterfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Stewart

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Addie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11-1887

8. AGE: Years: 60 | Months: 3 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Bakery Employe

11. Industry or business: Koester Bakery

FATHER
12. Name: Charles Stuart
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Mary Stubb
15. Birthplace: Virginia

16 (a) Informant: Mrs Addie Stuart
(b) Address: 3040 Chesterfield Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11-19-47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Baltimore Md

18 (a) Funeral director: Williams Cook Inc
(b) Address: 1717 St Paul St

NOV 17 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1947, at 4:50 P.M.

21. I certify that I took charge of the remains described above, held an Aug Ed Chas G. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: William G. Kelbrick M.D. Medical Examiner.
Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56984 B.C.# 10726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106c

Registered No. G56984

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Balto Gen
(c) Hospital or institution: Hosp. 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Baltimore
(c) City or town Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 3117 Woodland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Henderson.
3 (b) If veteran, name war
3 (c) Social Security Account No. None
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 7 1946
8. AGE: Years 1 Months 5 Days 17 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
12. FATHER Name Frederick C Henderson
13. Birthplace Baltimore Md
14. MOTHER Maiden Name Alberta D Sargeant
15. Birthplace Lowell Mass
16 (a) Informant Frederick C Henderson
(b) Address 3117 Woodland Ave
17 (a) Tuesday (Burial, cremation, or removal) (b) Date thereof 11 18 47 (month) (day) (year)
(c) Cemetery or crematory Parkland Mem Pk
Location Baltimore Md
18 (a) Funeral director Wellington Cook & Eve
(b) Address 1217 St Paul St
19 (a) (Date rec'd by registrar) (b) Huntington Williams Md (Signature)

NOV 17 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1947, at 9.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1947 to 11/16 1947, and that I last saw h[illegible] alive on 11/16 1947.

Immediate cause of death	Duration
Cardio-respiratory arrest.	
Due to Bronchial obstruction	
Due to Trachea - bronchitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lorand Lucher MD M. D.
Address West Baltimore Med Bldg

11/16/47

G56985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 307

Registered No. G56985

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Southern Ave.
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Southern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES BREEBACK

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-9384A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emma Breeback
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1880

8. AGE: Years	Months	Days	If less than one day
67	2	13	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Retired

FATHER
12. Name Rudolph H. Breeback
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Katherine Gottschalk
15. Birthplace Balto., Md.

16 (a) Informant Mr. Rudolph Breeback
(b) Address 5012 Morello Rd., Balto.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Lasseter Funeral Home
(b) Address 7401 Belair Road

19 (a) NOV 17 1947 (Date recd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1947, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1944, to Nov 15 1947.
and that I last saw h[illegible] alive on Nov 15 1947.

Immediate cause of death: Acute Cardiac failure — Duplicate 11/15/47
Due to: Hemorrhage from a ruptured Thoracic Aorta — 11/15/47
Due to:
Other Conditions: Aneurism of Thoracic aorta — 11/11/45
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Reaver M. D.
Address 501 Keswick Rd. Date signed

VS 150

G56986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G56986

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Dunbarton Ave
(c) Hospital or institution: 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 14

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town 611 Dunbarton Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Elizabeth [redacted] Weyforth

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Robert
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1864

8. AGE: Years	Months	Days	If less than one day
83	1	30	..... hr. ..... min.

9. Birthplace Austria
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Charles Holacek
13. Birthplace Austria

MOTHER
14. Maiden Name not known
15. Birthplace " "

16 (a) Informant Mrs. Elizabeth Prince
(b) Address 611 Dunbarton Ave.

17 (a) Burial (b) Date thereof 11/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) NOV 17 1947 (b) Huntington for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1947, at 1145 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Nov 1947, and that I last saw her alive on Nov 14 1947

Immediate cause of death	Duration
Arteriosclerotic	yrs
Cerebrovascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature F. V. D. Mack
Address 513 E. 39th Date signed Nov 15 1947 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G#6987 B.C. # 49128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓64

Registered No. G56987

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3113 Leighton Rd
(c) Hospital or institution: 15-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Leighton Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Louis Kolodner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/28/47

8. AGE: Years | Months: 1 | Days: 18 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis J. Kolodner, M.D.
13. Birthplace Balto Md

MOTHER
14. Maiden Name Lee
15. Birthplace Balto Md

16 (a) Informant Dr Louis Kolodner
(b) Address 3113 Leighton Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Kaufman Inc
(b) Address 2100 Eutaw Place

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Pulmonary edema — Duration:
Due to: asphyxia
Due to: enlarged thymus
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As noted above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Tobias Weinberg M. D.
Address Walbrook Apt. 6A Date signed 11/16/47

Thomas J. Kennedy, M.D. X

G56988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 111 B

G56988

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Edmonston Ave
(c) Hospital or institution: I 18.2

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Edmonston Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Harry M Brown.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Ceder

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years ✓✓ | Months | Days | If less than one day, ... hr. ..... min.

9. Birthplace Russia.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name not known
13. Birthplace Russia

MOTHER
14. Maiden Name not known
15. Birthplace Russia.

16 (a) Informant Wife
(b) Address

17 (a) Burial (b) Date thereof 11-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Pennsylvania

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Place

19 NOV 17 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16, 1947, at 4:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary Edema

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature William G Helbrich M.D.
Medical Examiner.
Date signed Nov 16, 1947

VS 181

X

G56989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓50

Registered No. G56989

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3702 Nortonia Rd.
(c) Hospital or institution: The Maund Convalescent Home 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 N. Arguilla St. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No) If yes, name country

3 (a) FULL NAME Sadie Rosen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 48 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta
15. Birthplace Russia

16 (a) Informant: Samuel Rosen
(b) Address 803 Asgarth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-47 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1947, at 12:02 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Nov 16 1947 and that I last saw h.. alive on Nov 15 1947

Immediate cause of death	Duration
Carcinomatosis	18 mo.
Due to Carcinoma of the Left Breast	1 yr.
Due to	
Other Conditions Jaundice	3 days.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rechvg. Kalman M.D. M. D.

Address 3700 Nortonia Rd Date signed Nov 17 1947

X

G56990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56990

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 Madison Ave.
(c) Hospital or institution: 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Madison ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Anna Gough

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Thomas Gough

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22 1871

8. AGE: Years 76 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Wormley

13. Birthplace Va

MOTHER 14. Maiden Name Etta ?

15. Birthplace Richmond Va

16 (a) Informant Miss Cora Williams

(b) Address 1996 Dean St. Bklyn N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-47 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem Park

Location Baltimore Co.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) NOV 17 1947 (Date rec'd by Registrar) (b) Contagious Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Nov 17 1947 and that I last saw h[illegible] alive on Nov 17 1947

Immediate cause of death: Cerebrovascular Accident

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 15 min

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [signature] M. D.

Address Date signed Nov 17 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Register G56991

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 E Biddle St
(c) Hospital or institution: 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 E Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catharine Josephine Bauer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John L Bauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14 1891

8. AGE: Years	Months	Days	If less than one day
56	8	1	hr. min.

9. Birthplace Blaskus Va (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER 12. Name John Antkowik
FATHER 13. Birthplace Poland
MOTHER 14. Maiden Name Dont Know
MOTHER 15. Birthplace " "

16 (a) Informant Mrs Florence Cramer
(b) Address 721 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Catty

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2205 Eden St

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 November 1947, at 3:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Nov. 1947, to 15 Nov. 1947, and that I last saw her alive on 14 Nov. 1947

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to Hypertensive Cardio Vascular Disease	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kamm M.D.
Address 1-01 Sheridan Ave. Balto. Date signed 15 Nov. 47

X

G56992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G56992

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important. Be sure to give correct age

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST.
(c) Hospital or institution: MERCY HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 7501 BERKSHIRE RD. (If rural give location) MERCY HOSP. CALVERT ST.
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GEORGE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/12/47

8. AGE: Years	Months	Days	If less than one day
		2	0 hr. 2 min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name HEBER T. GEORGE, JR.

13. Birthplace PA.

MOTHER 14. Maiden Name DOROTHY HEIGES

15. Birthplace PA.

16 (a) Informant MOTHER

(b) Address 7501 BERKSHIRE RD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18th (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location City

18 (a) Funeral director Wellstood Funeral Home

(b) Address 2008 Pleasant St

19 (a) Nov 17 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16 1947, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1947 to 11/16 1947, and that I last saw h[illegible] alive on 11/16 1947

Immediate cause of death RESP. FAILURE — Duration

Due to CONGENITAL HEART FAILURE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elden H. Pentz

Address Mercy Hosp. Date signed 11/16/47

VS 150

G56993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G56993

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert St.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 45 Wise Ave.
(If rural give location)
(e) Citizen of foreign country? Not (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Shiflett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry Shiflett

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1889

8. AGE: Years 58 | Months 3 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name George Lilly
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ellie Young
15. Birthplace Balto. Md

16 (a) Informant ?
(b) Address ?

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem
Location Balto Md

18 (a) Funeral director Wm J Tyrell Home
(b) Address 1 of Orleans

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1947 1947 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11, 1947 to Nov. 16 1947 and that I last saw h.e.y. alive on Nov. 16, 1947

Immediate cause of death	Duration
Ventricular Fibrillation	3 min.
Due to Myocardial Infarction	7 days
Due to Coronary occlusion	2 days
Other Conditions Obesity (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Li Puma M. D.
Address Mercy Hosp Date signed 11-16-47

G56994

BALTIMORE CITY HEALTH DEPARTMENT — Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1838 N. Spring St.
(c) Hospital or institution: 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 N. Spring St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes name country

3 (a) FULL NAME Mary Louise Grove (Mary Cross)
3 (b) If veteran, name war
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race Cor.
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) December 6, 1877
8. AGE: Years 69 Months 11 Days 7 If less than one day hr. min.
9. Birthplace Calvert County, Md. (Town, county, and State)
10. Usual Occupation Domestic (Unemployed)
11. Industry or business

FATHER
12. Name Louis Grove
13. Birthplace Calvert County, Md.

MOTHER
14. Maiden Name Silvinia Wilson
15. Birthplace Calvert County, Md.

16 (a) Informant Ruth Lee (Sister)
(b) Address 1838 N. Spring St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director Robert L. Gruver
(b) Address 1216 N. Caroline St.
19 (a) NOV 17 1947 (Date received by registrar) (b) Huntingtown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1947, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Nov 13 1947, and that I last saw h.e.w. alive on Nov 10 1947.

	Duration
Immediate cause of death: Aortic Regurgitation	Sept 1946
Due to:	
Due to:	
Other Conditions: Chronic Nephritis, Cardiac Hypertension (Include pregnancy within 3 months of death)	Sept 1946

Date of operation: none
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph L. Young, M.D.
Address 1429 E. Monument St. Date signed 11/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

056995 Dec 356995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 056995

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1437 E. Eager St.
(c) Hospital or institution: 10-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1437 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Estella Gaines.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow.

6 (b) Name of husband or wife: George Gaines

6 (c) If wife, age if alive, or years

7. Birth date of deceased (mo., day, yr.) July 27, 1901

8. AGE: Years 46 Months 3 Days 17 If less than one day hr. min.

9. Birthplace Charles-Town. W. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Billie Walker.
13. Birthplace Mekinsey.

MOTHER
14. Maiden Name Elsa Tirell
15. Birthplace Mekinsey

16 (a) Informant Frank Thomas Step Son
(b) Address 1437 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park
Location

18 (a) Funeral director Robert F. Young
(b) Address 1216 N. Carolina St.

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1947 at 11:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9, 1947 to Nov. 13 1947 and that I last saw h.. alive on Nov. 13 1947.

Immediate cause of death: Hypostatic Pneumonia — Duration 2 days

Due to: Cachexia — —

Due to: Cancer - Womb Known — 1yr+

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1422 E. Eager St Date signed Nov. 17/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G56996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G56996

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 S Calhoun St
(c) Hospital or institution: — 19-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 S Calhoun St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Henry Bernhard Krummel

3 (b) If veteran, name war: none
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 83 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Ret. Tailor Trimmer

11. Industry or business Tailoring

FATHER
12. Name Adolph Krummel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Ruth Zinken
(b) Address 110 S Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17-47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey Md

18 (a) Funeral director Geo L Beyer Jr
(b) Address 1512 Bolton St

19 NOV 17 1947 (Huntington Williams, M.D.)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1947 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Nov 13 1947 and that I last saw h[illegible] alive on ..... 19 .....

Immediate cause of death Coronary Thrombosis — Duration 3 days
Due to Cerebral Arterio Sclerosis — 4 yrs
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature [illegible] Miles
Address 631 [illegible] Date signed 11/16/47 M. D.

VS 150

G56997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G56997

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner
(c) Hospital or institution: Wood Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 York Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Germany

3 (a) **FULL NAME** Lena Herzog CAROLINA HERZOG

3 (b) If veteran, name war ———

3 (c) Social Security Account No. ———

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William Robert Herzog

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1865

8. AGE: Years 82 | Months 3 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant John R. Herzog
(b) Address 101 Shealey Ave., Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Maryland

18 (a) Funeral director John Burns Sons
(b) Address Towson, Maryland

NOV 17 1947 (b) Huntington Williams M.D.
(Date received by registrar) (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1947, at 920 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1947 to 11-15 1947 and that I last saw h... alive on ... 19...

Immediate cause of death Cardiac Standstill
of Unknown Origin
Due to Arteriosclerotic —
Cardio-Vascular Renal Dis.
Due to Recent Amputation
of right lower Extremity

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation 11-15-47

Major findings of operation: Gangrene - right foot

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Gerhardt M.D.
Address West Balto Gen'l Date signed 11/15/47

1310

1319 Light St.

56998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G56998

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3509 Keswick Road
(c) Hospital or institution: 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 Keswick Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys M. Ruby.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Byron Ruby.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1901

8. AGE: Years 46 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Howard F. De Haven

13. Birthplace Maryland

14. Maiden Name Fannie B. Miller

15. Birthplace Maryland.

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/47 (month) (day) (year)

(c) Cemetery or crematory Loraine

Location

18 (a) Funeral director Cunnold & Donovan

(b) Address 3615-17 Pinkney Ave

19 NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1947, at 1 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9, 1947, to Nov. 17, 1947, and that I last saw h alive on Nov. 17, 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Chronic myocarditis	
Due to Rheumatic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. P. Faulkner M.D.

Address 1319 Light St. Date signed 11/17/47

VS 150

X

G56999 1816 St Paul St.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56999

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3418 Chestnut Ave
(c) Hospital or institution: 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3418 Chestnut Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary N. Mahar.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed.

6 (b) Name of husband or wife Robert Mahar.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1870

8. AGE: Years	Months	Days	If less than one day
77	7	11	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Wm. B. Stone.
13. Birthplace Md.

MOTHER
14. Maiden Name Susan V. Shaffer.
15. Birthplace Md.

16 (a) Informant Mrs. Velma I. Bigham.
(b) Address 3418 Chestnut Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Nov. 19 1947 (month) (day) (year)
(c) Cemetery or crematory New Freedom.
Location New Freedom, Pa.

18 (a) Funeral director Chenoweth & Hanover.
(b) Address 2618-12 Chestnut Ave.

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1947 at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to Nov 16 1947 and that I last saw h. alive on Nov 15 1947

Immediate cause of death Cerebral Hemorrhage — Duration 2 wks.

Due to Hypertension — 10 yrs

Due to Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert M. Frater M. D.
Address 2424 St. Paul St. Date signed Nov. 17-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 657000

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 East St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Dominic Fazio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Fazio

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Jan 21 1905

8. AGE: Years 42 | Months 9 | Days 25 | If less than one day ..... hr. ..... min. 1895

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business United States Coast Guard

FATHER
12. Name Amoruth - Fazio
13. Birthplace Italy

MOTHER
14. Maiden Name [illegible] Unknown
15. Birthplace [illegible]

16 (a) Informant Mrs Anna Fazio
(b) Address 309 East St.

17 (a) Burial (b) Date thereof 11/19/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Boland Road.

18 (a) Funeral director Walter T Schweinsberg
(b) Address 1126 West Cross St.

NOV 17 1947 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/15 1947, at 5-45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature R. J. Fulcinski M.D.
Medical Examiner.
Date signed 11/16/47

G57001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

Registered No. G57001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1950 Sponson St.
(c) Hospital or institution: 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1950 Sponson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence V. Schwemmer.

3 (b) If veteran, name war: none.

3 (c) Social Security Account No. none

4. Sex: Female. 5. Color or race: White. 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Louis L. Schwemmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April-15-1873.

8. AGE: Years 74 | Months 6 | Days 30 | If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation House Wife.

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. August Schwemmer.
(b) Address 630 - Portland St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Nov. 17-47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick, Ave.

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November, 14 1947, at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to NOV 14 19 47 and that I last saw her alive on NOV 14 19 47

Immediate cause of death: Cerebral Apoplexy - Thrombosis - | Duration: 3 day

Due to:

Due to:

Other Conditions: Senile Bronchopneumonia | 3 day
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1501 Eutaw Pl. Date signed

x 11/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 057002

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 345 W. Preston St.
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 345 W. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-1-1893

8. AGE: Years 54 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Archie Moore

13. Birthplace N

MOTHER 14. Maiden Name ?

15. Birthplace South Carolina

16 (a) Informant Mrs. Williams

(b) Address 345 W. Preston Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 14 47 (month) (day) (year)

(c) Cemetery or crematory Mt Caby Cem

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave

NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1947 at 11.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1947, to Nov 12 1947 and that I last saw h alive on 19

Immediate cause of death Arteriosclerotic Cardiac Renal disease — Duration 7 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J.R. Coasey M.D.

Address Date signed Nov 13 1947 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57003

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 Hanover St.
(c) Hospital or institution: 23-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Hanover St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth Schuch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Frank Schuch
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 19, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	26	— hr. — min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Scherer
13. Birthplace Germany

MOTHER
14. Maiden Name ? ?
15. Birthplace Germany

16 (a) Informant Frank F. VonCalin (Grandson)
(b) Address 707 Chanel St. Balto 25, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md.

18 (a) Funeral director A. Howard Evans
(b) Address 4005 Harford Ave. City (30)

19 NOV 17 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1947, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12 1947 to 11/15 1947 and that I last saw her alive on 11/15 1947.

Immediate cause of death	Duration
Coronary Occlusion, Arteriosclerotic Cardiovascular Disease	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature H. Williams M. D.
Address 107 E. West St. Date signed 11/17/47

VS 150

G57004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓55E

G57004 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address HARFORD RD. & HERRING RUN
(c) Hospital or institution: SYDENHAM HOSPITAL 28-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 8 MOS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 5300 NEW EDMONDSON AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ZANDRA LYNN SMITH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1946

8. AGE: Years	Months	Days	If less than one day
1	2	13	hr. min.

9. Birthplace Riverdale, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Raymond E. Smith

FATHER 13. Birthplace ILLINOIS

MOTHER 14. Maiden Name Martha Herman

MOTHER 15. Birthplace MARYLAND

16 (a) Informant Raymond E. Smith

(b) Address 5300 New Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/47 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge

Location Howard Co Md

18 (a) Funeral director Ridgely MacGabb

(b) Address Catonsville Md

19 (a) NOV 19 1947 (Date rec'd by Registrar) (b) Livingston Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1947 to Nov 15 1947 and that I last saw her alive on Nov 15 1947

Immediate cause of death	Duration
Respiratory failure	
Due to	
Due to Lymphoblastoma	2 weeks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Nov. 15, 1947

Major findings of operation: Biopsy cervical gland & of autopsy: Lymphoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward A. Cooper M. D.

Address Sydenham Hosp. Date signed Nov. 15, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G57005 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 East 25th St # 18
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Helen Curtis Poppington

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1872

8. AGE: Years	Months	Days	If less than one day
75	3	6	hr. min.

9. Birthplace Baltimore, Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Nicholas John Poppington
13. Birthplace Maryland

MOTHER
14. Maiden Name Eleanor Berkley
15. Birthplace Maryland

16 (a) Informant Miss Elizabeth H. Sappington
(b) Address 725 St. Johns Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. T. Mearns & Son
(b) Address 805 N. Calvert St.

19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar

NOV 17 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1947, at 5:25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1947 to Nov. 16 1947, and that I last saw her alive on Nov. 16 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Auricular Fibrillation	
Due to Coronary occlusion	
Other Conditions Cardio Vascular Disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Burkhart, M. D.
Address Md. Gen'l Hosp. Date signed 11/16/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5112

G57006
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1364 n. Calhoun St
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1364 n. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John M. Grant
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	col.	married

6 (b) Name of husband or wife Hattie Grant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) april 4, 1876

8. AGE:	Years	Months	Days	If less than one day
	71	7	10	hr. min.

9. Birthplace n. c. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Hiram Grant
13. Birthplace n. c.

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Hattie Grant
(b) Address 1364 n. Calhoun st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-47 (month) (day) (year)
(c) Cemetery or crematory mt auburn cem.
Location George B. Nelson

18 (a) Funeral director 1303 Presstman st
(b) Address Huntington Williams, Md

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH november 14 1947, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945, to 11/14 1947, and that I last saw him alive on 11/10 1947.

	Duration
Immediate cause of death: Cancer prostate with metastases in bones	2 yrs +
Due to: + Lung —	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry A. McCarty
Address 57 W. Preston Date signed 11/15/47

G57007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-21

G57007
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 Ettings St -
(c) Hospital or institution: 14.3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Ettings
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Blackwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1914

8. AGE: Years 33 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Domestic -

11. Industry or business

FATHER
12. Name -
13. Birthplace -

MOTHER
14. Maiden Name Lula Blackwell
15. Birthplace Maryland.

16 (a) Informant Lula Blackwell
(b) Address 2123 Ettings

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Northern Cemetery
Location Northern Cemetery Co. Rd

18 (a) Funeral director Geo. H. Helton
(b) Address 1300 Eutaw Place

NOV 17 1947 (b)
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 14 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 10 1947, to Nov 14 1947, and that I last saw h[illegible] alive on Nov - 14 1947.

Immediate cause of death Chronic Endocarditis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration
..

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Greenstein M.D.

Address 1212 W Lee St Date signed Nov 17/47

VS 150

G57008

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G57008 Registered No. 13C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1846 Lorman St
(c) Hospital or institution: 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1846 Lorman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Priscilla Hanley
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-9-18
8. AGE: Years 29 Months 9 Days 7 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Buddie Handy
13. Birthplace Md
MOTHER 14. Maiden Name Ollie McCready
15. Birthplace Md
16 (a) Informant Ollie McCready
(b) Address 1846 Lorman St.
17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 11-21-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem. Location West Fort Balto. Md Inc.
18 (a) Funeral director Wilmer H. Fleming Home
(b) Address 927 N. Mount St.
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16- 1947, at 5.30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1947 to 11/16 1947, and that I last saw h alive on 11/15 1947.

Immediate cause of death	Duration
(a) Pulmonary Tuberculosis	4 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. H. Jackson M.D.
Address 1600 Eutaw Pl. Date signed 11/17/47

VS 150

G57009 114235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 199

Registered No. G57009

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave/
(c) Hospital or institution: Baltimore City Hospitals 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 10-12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 S. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nuliaus Hilton Littlejohn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March. 22-1916

8. AGE: Years	Months	Days	If less than one day
31	7	24	hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ed. Littlejohn
13. Birthplace N, Carolina

MOTHER
14. Maiden Name Ida Shoemaker
15. Birthplace S.Carolina

16 (a) Informant B.C.H.Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof 11/17/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Washington D.C.

18 (a) Funeral director Malfant Lehey Inc.
(b) Address 424-R St N.W.

19 (a) NOV 17 1947 Registrar Washington Williams, M.D. Registrar
(Date received by Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15- 1947, at 2:35PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1947 to Nov. 15 1947, and that I last saw h im alive on Nov. 15 1947

Immediate cause of death	Duration
Uremia	2 wks
Due to Penarterritis Nodosa, Questionable	6 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above on gross

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J.C. Robinson Jr
Address B.C.H. City Dept. Date signed 11/16/47 M.D.

X

G57010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G57010
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 W. Mulberry
(c) Hospital or institution: 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 W. Mulberry
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John D. Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day. yr.) June 7, 1876

8. AGE: Years	Months	Days	If less than one day
71	5	6	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business

FATHER
12. Name Henry Hicks
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Bessie Pittman
(b) Address 634 Eislin St

17 (a) Burial (b) Date thereof 11/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co Md

18 (a) Funeral director Daniel L. Brown & Son
(b) Address 108 N Montgomery St

19 (a) (b) Registrar Williams M.D.
Registrar

NOV 17 1947
VS 1M

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13/1947 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1947 to 11/13/1947 and that I last saw h[illegible] alive on 11/13/1947

Immediate cause of death	Duration
Due to Cerebral Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11/17/47

G57011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13113

Registered No. G57011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Haverhill Rd.
(c) Hospital or institution; 25-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Haverhill Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H Fitzmaurice

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Abbie (Friersh)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1879

8. AGE: Years	Months	Days	If less than one day
68	6	12	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frederick Fitzmaurice
13. Birthplace Ireland

MOTHER
14. Maiden Name Fannie Hayes
15. Birthplace ?

16 (a) Informant Mrs Abbie Fitzmaurice
(b) Address 1119 Haverhill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20/1947 (month) (day) (year)
(c) Cemetery or crematory LOUDAN PARK
Location 3201 FREDERICK AVE

18 (a) Funeral director Harry H Wiegle
(b) Address 4647 EDMONDSON AVE

19 (a) (Date rec'd by registrar) NOV 17 1947 (b) Burial Permit Issued

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to Nov 17 1947 and that I last saw h[illegible] alive on Nov 16 1947

Immediate cause of death Chronic nephritis — Duration

Due to

Due to

Other Conditions Bronchial asthma Coronary artery heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 3321 Frederick Date signed 11/17/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered 657012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1558 Moreland Ave.
(c) Hospital or institution: 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1558 Moreland Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ILKA ROSENBAUM WEISKOPF.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b), Name of husband or wife: Hiram J. Weiskopf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1893.

8. AGE: Years 54 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name B. Z. Rosenbaum,
13. Birthplace Germany.

MOTHER
14. Maiden Name Dora Strauss,
15. Birthplace Balto. Md.

16 (a) Informant Mr. Joseph B. Weiskopf,
(b) Address 1558 Moreland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/47. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 Filed Nov 19 1947 (b) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 17th. 1947. 2.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1947 to Nov. 17 1947 and that I last saw h[illegible] alive on Nov 17 1947.

Immediate cause of death Coronary Embolism

Due to

Due to

Other Conditions Hypertension — Duration: 6 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harris Sonneborn

Address 1816 W. North Ave. Date signed 11/19/47 M. D.

VS 150

G57013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G57013

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 S High St
(c) Hospital or institution: 32

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 S High St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Fermes Palmisano

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed~~, or divorced.
Female	White	Married

6 (b) Name of ~~husband~~ or wife Vincent L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26 1885

8. AGE: Years	Months	Days	If less than one day
62	8	17	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Joseph Fermes
13. Birthplace Italy

MOTHER
14. Maiden Name Catherine Fermes
15. Birthplace Italy

16 (a) Informant Vincent L Palmisano
(b) Address 320 S High St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Old Frederick Road

18 (a) Funeral director John A Moran
(b) Address 2310 E Baltimore St

19 NOV 17 1947 (Date rec'd by registrar) Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947, to Nov. 15 1947, and that I last saw HER alive on Nov. 15 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Metastatic Carcinoma stomach, liver, lungs	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles G. MacMunn
Address 2911 E. Balt St 24 Date signed Nov. 17 1947 M. D.

VS 150

G57014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G57014

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 Oakhill Ave
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Oakhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Westphal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband [illegible] Carrie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14 1871

8. AGE: Years	Months	Days	If less than one day
76		1	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Henry Westphal
13. Birthplace Germany

MOTHER
14. Maiden Name N. Record
15. Birthplace Germany

16 (a) Informant Mrs. J. Westphal
(b) Address 2233 Gilsquith St

17 (a) Burial (b) Date thereof 11-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location 5510 Harford Rd.

18 (a) Funeral director John C. Moran
(b) Address 3000 E Baltimore St

19 NOV 17 1947 (b) [illegible] for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13/1947, to 11/15/1947, and that I last saw h[illegible] alive on 11/14/1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Cerebral Arteriosclerosis	4 yrs
Due to	
Other Conditions Hypertension	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Waste M. D.
Address 532 E 22nd St Date signed 11/17/47

VS 150

G57015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G57015 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 W.Madison St.
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 W.Madison (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY MARPLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John B. Marple

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, (1913) 19

8. AGE: Years	Months	Days	If less than one day
34 (33)	11	(19) 18	hr. min.

9. Birthplace Wheeling, W.Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Okey J. Valentine
13. Birthplace W.Va.

MOTHER
14. Maiden Name Margaret Sayre
15. Birthplace Ohio.

16 (a) Informant Mr. John B. Marple
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/47 (month) (day) (year)
(c) Cemetery or crematory
Location Wheeling, W.Va.

18 (a) Funeral director Wm. J. Tichnor & Sons
(b) Address North & Pa. Aves.

19 NOV 17 1947 (Date rec'd by Registrar) (b) Huntington, W.Va. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1947, at 9.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 11-17-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

657016 46B Registered No. 657016

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital E-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 67 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3431 Ravenswood Ave #13
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Fraser (FRANCE)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-10-0165

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Ethel Fraser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25, 1868

8. AGE: Years	Months	Days	If less than one day
79	2	21	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name James M. Fraser
13. Birthplace Virginia

MOTHER
14. Maiden Name Catherine Bell
15. Birthplace Maryland

16 (a) Informant Ethel L. Fraser
(b) Address 3431 Ravenswood Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 19/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Pikesville, Md.

18 (a) Funeral director Philip Heuisler Sons
(b) Address 2024 Eutaw Pl. Baltimore, Md.

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1947, at 7:26 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 1947 to Nov. 15 1947, and that I last saw h.IM alive on Nov. 15 1947

Immediate cause of death Respiratory Failure — Duration

Due to Carcinoma of Stomach

Due to

Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Burkhart M. D.
Address Md. Geni Hosp Date signed Nov 15, 1947

G57017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G57017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1644 Ashburton St.
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1644 Ashburton Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Davis Jennings

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	213-09-5680

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FM	W	Widowed

6 (b) Name of husband or wife Edgar A. Jennings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1891

8. AGE: Years	Months	Days	If less than one day
56	8	28	hr. min.

9. Birthplace Maryland Baltimore
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business Home

FATHER
12. Name George Washington Roberts
13. Birthplace Unknown

MOTHER
14. Maiden Name Lucy A. Rosser
15. Birthplace Petersburg Va.

16 (a) Informant Allen Jennings
(b) Address 1644 Ashburton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director George W. Little
(b) Address 3700 Edmondson Ave.

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1947 at 12:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-2-47 19 to 11-16-47 19, and that I last saw h[illegible] alive on 11-15-47 19

Immediate cause of death: Cerebral Accident — Duration 2 days
Due to: Apoplexy — 2 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry S. Gimbel
Address 203 Grande Date signed 11-17-47

X

657018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 657018

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp. 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo, 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Abell Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Smith Robertson
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Mr. Stewart Robertson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JAN. 28, 1907
8. AGE: Years 40 | Months 9 | Days 18 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name James McC. Smith.
13. Birthplace Maryland. (Calvert Co.)

MOTHER
14. Maiden Name Julia Mabs
15. Birthplace Maryland (Balto.)

16 (a) Informant Stewart Robertson
(b) Address 3112 Abell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 19 47, at 3:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 19 47 to Nov. 16 19 47, and that I last saw h.e.r. alive on 15 19 47.

	Duration
Immediate cause of death: Acute intestinal hemorrhage	1 day
Due to: Perforation of ileum	4 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Perforation of ileum, G.I. hemorrhage
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. D.
Address Date signed

VS 150

HAP X 11-15-47

G57019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

G57019 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 So. Augusta Ave
(c) Hospital or institution: 20-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 So. Augusta Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William S. Wilmes

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Margaret E. Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12th 1870

8. AGE: Years	Months	Days	If less than one day
77	9	4	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Copper Co.

FATHER
12. Name Bernard Wilmes
13. Birthplace Germany

MOTHER
14. Maiden Name Kate Swalkenberg
15. Birthplace Germany

16 (a) Informant Mrs. Margaret E. Wilmes
(b) Address 10 So. Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Lethe Cem. Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Sequenzia
(b) Address 900-05 Hollins St.

19 NOV 17 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16th 1947, at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h[illegible] alive on November 16 1947.

	Duration
Immediate cause of death Angina Pectoris	6 wks.
Due to Chronic Interstitial Cardio-vascular disease	10 yr.
Due to Chr. Rheumatism	50 yr. (?)
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nelson K. Gallagher M.D.
Address Catonsville-28, Md. Date signed 11/17/47

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1107

Registered No. 657020

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Sinai Hospital
(c) Hospital or institution: 26-3
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 3016 Mayfield Avenue
(If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

3 (a) FULL NAME: MR JOHN J. CASWELL

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary C. & Marion King Caswell

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 20, 1865

8. AGE: Years: 81 | Months: 11 | Days: 27 | If less than one day: 26 hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: C. & P. Telephone Co.

FATHER
12. Name: Robert Caswell
13. Birthplace: Md.

MOTHER
14. Maiden Name: Anna Nichols
15. Birthplace: Md.

16 (a) Informant: Mr. William M. Caswell
(b) Address: 3016 Mayfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-19-47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road, 14

19 (a) NOV 17 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-16 - 1947, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1947, to 11-16 1947 and that I last saw h[illegible] alive on 11-16 1947.

Immediate cause of death: Bronchopneumonia — Duration:

Due to:

Due to:

Other Conditions: Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Allen J. Wolinsky M. D.
Address: Sinai Hospital Date signed: 11-16-47

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G5202144 1244 — 131a — Registered G52021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co. Spurrier P.O. Md.
(c) City or town Edgemere (If outside city or town limits, write RURAL and give town)
(d) Street No. 6707 River Drive Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward S. Hickey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Mr.

6 (b) Name of husband or wife Elsie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/11

8. AGE: Years	Months	Days	If less than one day
36	6	0	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Elec worker
11. Industry or business Bethl. Steel Co.

FATHER
12. Name John A. Hickey
13. Birthplace Md.

MOTHER
14. Maiden Name Rachel Sanders
15. Birthplace Md.

16 (a) Informant Mrs. Elsie Hickey
(b) Address 6707 River Drive Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-47 (month) (day) (year)
(c) Cemetery or crematory Mordant Park
Location Md.

18 (a) Funeral director J. J. Lupp
(b) Address 5305 Harford Rd.

19 NOV 17 1947 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1947, at 8:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1947 to Nov. 14 1947. and that I last saw him alive on 11/14 1947.

Immediate cause of death	Duration
Uremia	
Due to Arteriolonephrosclerosis	
Due to Malignant Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Hopkins M. D.
Address Johns Hopkins Hosp. Date signed 11-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57022 A - 90987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G57022

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 99
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Stevens

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11. 1913

8. AGE: Years	Months	Days	If less than one day
34	8	5	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Stevens
13. Birthplace Va.

MOTHER
14. Maiden Name Nanny
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-47 (month) (day) (year)
(c) Cemetery or crematory M.Y. Calvary
Location C. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1642 E. Preston St

19 NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williams

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 19 47 at 7.40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 19 46 to Nov. 16 19 47 and that I last saw h. im alive on Nov. 16 19 47

Immediate cause of death	Duration
Pulmonary Tuberculosis Ulcerated	1 yr 7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Robinson Jr M. D.
Address Balt City Hosp Date signed 11/16/47

G57023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G57023

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: South Balto Gen Hosp 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Bloomsbery St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Norma Bury

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Charles Bury

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Jan 22 1896

8. AGE: Years 51 (52) | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Hoover
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Englehart
15. Birthplace Baltimore

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director Flippen & Fleming
(b) Address 1476 Light St Williamsport, Md

19 (a) NOV 17 1947 (Date received by Registrar) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1947, at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1947 to Nov 14 1947, and that I last saw her alive on Nov 14 1947.

Immediate cause of death: Hypertensive cardio-vascular disease — Duration

Due to

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Fullon M. D.

Address Balto Gen Hosp Date signed 11/14

VS 150

937

G57024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G57024

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 75yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 E. Chase St - 2
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Danaher

3 (b) If veteran, name war: Unknown
3 (c) Social Security Account No. Unknown

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
75	?	?	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Street Cleaning dept
11. Industry or business

FATHER
12. Name Daniel Danaher Sr.
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary -?
15. Birthplace Ireland

16 (a) Informant Mary E. Danaher
(b) Address 712 Whitmore Ave

17 (a) Burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John E. Moran
(b) Address 3000 E. Baltimore St

19 (a) NOV 17 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1947, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1947 to Nov 16 1947 and that I last saw him alive on Nov 16 1947

Immediate cause of death: Fractured Skull — Duration: 7 days
Due to: Fall down steps
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation Nov 9, 1947
Major findings of operation: Decompression fractured skull
or autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Nov 9 1947 at 1 00 P.M.
(c) Where did injury occur? Baltimore (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fall down steps
23. Signature D. Otis Montgomery M.D.
M. D.
Address Mercy Hospital Date signed 11-16-47
For Dr. J.R. Devron by Howard J. Nelson, M.D.

VS 150

G57025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G57025 ✓ 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28-1
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5038 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD GUNTHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife Florence Gunther

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) APRIL 14, 188[illegible]

8. AGE: Years 66 | Months 7 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired Laborer

11. Industry or business Gen. Contracting.

FATHER
12. Name Hammond J. Gunther
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Elizabeth Goudy
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Florence Gunther
(b) Address 5038 Reisterstown Rd.

17 (a) Burial (b) Date thereof 11/18/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olive Cem.
Location Randallstown Md.

18 (a) Funeral director C. Vernon Lessenden
(b) Address 4611 Park Heights.

19 NOV 17 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/15/47 19 , 5:40 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John G. Devro M.D.
Medical Examiner.

Date signed 11/15/47

G57026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G57026

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 S. East Ave.
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 S. East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE W. WOLF

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 216-20-8740

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1926.

8. AGE: Years 21 | Months 0 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Heat and Power System Co.

FATHER
12. Name William J. Wolf
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Edna E. Heinlein
15. Birthplace Baltimore, Md.

16 (a) Informant William J. Wolf (Father)
(b) Address 1014 S. East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11- 19- 47. (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd. Balto. CO. Md.

18 (a) Funeral director Charles S. Seiler
(b) Address 901 S. Conkling St.

19 (a) NOV 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1947, at 11 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946, to Nov 16 1947 and that I last saw h.im alive on Nov 16 1947

Immediate cause of death	Duration
Carcinoma of Sigmoid Colon	1 Mos.
Due to	
Due to	
Other Conditions Nil	

(Include pregnancy within 3 months of death).
Date of operation Oct 15. 1947.
Major findings of operation: Carcinoma of Colon.
of autopsy: Nil

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. A. Schumunk M. D.
Address 842 S. Eastern Ave. Date signed 11/17/47

G57027

BALTIMORE CITY HEALTH DEPARTMENT ✓ G57027 Registered No.

CERTIFICATE OF DEATH 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Mc Donald (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Joh Louis Henry Joh

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1864

8. AGE: Years 83 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Farmer
11. Industry or business Retired

FATHER
12. Name Adam Joh
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Stauser
15. Birthplace Germany

16 (a) Informant Raymond Joh
(b) Address 3611 McDonald Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19 1947 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Maryland

18 (a) Funeral director George F. Ephard
(b) Address 3101 Pelham Ave

19 (a) (Date rec'd by registrar) (b) Thurston Williams, Registrar

NOV 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Nov 1947, at 1:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Oct 1947 to 16 Nov 1947 and that I last saw him alive on 16 Nov 1947

Immediate cause of death: Pneumonia Lobar Bilat — Duration:
Due to: Fracture Intertrochanteric femur left
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 10-14-47
Major findings of operation: 10-18-47 Fracture Inter trochanteric
of autopsy: Femur left

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 25/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10-12-47 at 3 M
(c) Where did injury occur? 32 to Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place) to Bed home
(e) Means of injury Fall to floor

23. Signature H E Mc Joh M. D.

Address St Agnes Date signed

To be approved by Med Examiner St Agnes Hosp 16 Nov 47

G57028 Segun
1261 E. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
93D

Registered No. G57028

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Gibbons Avenue
(c) Hospital or institution: 27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Gibbons Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie F. Beck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife George Beck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1872

8. AGE: Years	Months	Days	If less than one day
75	10	2	hr. min.

9. Birthplace Hungary
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Joseph Friederich
13. Birthplace Hungary

MOTHER
14. Maiden Name Magdelene Wagner
15. Birthplace Hungary

16 (a) Informant Mr. John J. Lipp
(b) Address 2828 Kentucky Avenue

17 (a) Burial (b) Date thereof 11-19-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) NOV 18 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16th, 1947, at M

21. I certify that death occurred on the date above stated that I attended deceased from 10/6 1947 to 11/16 1947 and that I last saw h alive on 11/12 1947.

Immediate cause of death Coronary Thrombosis — Duration 2
Due to Cerebral Hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury
23. Signature Samuel Lipp
Address 1261 E. North Ave. Date signed 11th 17 D.

VS 190

G57029 Blake

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G57029

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 Echodale Avenue
(c) Hospital or institution: 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Echodale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sebastian Bellistri

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth Bellistri
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1865

8. AGE: Years	Months	Days	If less than one day
82	8	16	hr. min.

9. Birthplace Augusta, Italy
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Dominico Bellistri
13. Birthplace Italy

MOTHER
14. Maiden Name Josephi ?
15. Birthplace Italy

16 (a) Informant Mrs. Elizabeth Bellistri
(b) Address 3500 Echodale Avenue,

17 (a) Burial (b) Date thereof 11-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 NOV 18 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1947, to 11-15 1947
and that I last saw h alive on 11-15 1947

Immediate cause of death Coronary Thrombosis — Duration 1 day
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Blake M. D.
Address 4508 Harford Rd. Date signed 11-17-47

VS 190

P.04
D-94320

G57030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 657030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 E. Pittsburg Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Di Leonardi

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-47

8. AGE: Years	Months	Days	If less than one day
—	—	3	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Albert J. Di Leonardi
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Etta Abbott
15. Birthplace Baltimore, Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery Johns Hopkins Medical Schoo NOV-17-1947
Location Commissioner of Health

18 (a) Funeral director
(b) Address

NOV 18 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14 1947, at 12:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1947, to 11-14 1947, and that I last saw h[illegible] alive on 11-14 1947.

Immediate cause of death	Duration
Prematurity & congenital anomalies	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert M. Carouge M. D.
Address 6226 Everall Ave. Date signed 11-17

VS 150

G57031 B.C. #23628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G57031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Govans (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 Howil Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Durall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/8/47

8. AGE: Years — | Months — | Days — | If less than one day 2 1/2 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Durall
13. Birthplace

MOTHER 14. Maiden Name Ruth Durall
15. Birthplace Md

16 (a) Informant Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1947 to Nov. 8 1947 and that I last saw him alive on Nov. 8 1947.

Immediate cause of death: Prematurity — Duration: 4 hours

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Hosp Date signed Nov 10 1947

NOV 17 1947
Johns Hopkins Medical Schoo
Commissioner of Health

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057032 B.C.T. V-99633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30F

Registered No. 057032

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 North Broadway
(c) Hospital or institution: The Johns Hopkins Hospital 74
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 Ruthland Avenue
Ruthland (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Conley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/9/47

8. AGE: Years | Months | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Frank Conley
13. Birthplace Virginia

MOTHER
14. Maiden Name Goldie Frazer
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Johns Hopkins Medical Schoo NOV-17-1947
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1947, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1947, to Nov. 10 1947, and that I last saw him alive on Nov. 10, 1947.

Immediate cause of death Congenital Syphilis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B C Williams M. D.
Address The Johns Hopkins Hospital Date signed 11-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57038 114752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125 B

Registered No. G57033

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18-B
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Christine Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Chas. F. Brooks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23- 1890

8. AGE: Years 57 | Months 0 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Wise

13. Birthplace Germany

MOTHER 14. Maiden Name Angeline Moore

15. Birthplace Maryland

16 (a) Informant B.C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19-1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto City

18 (a) Funeral director Pott & D. M. Walter

(b) Address 220 N. Stricker St.

19 Nov 18 1947 (Date filed by Registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1947, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1947 to Nov. 16 1947 and that I last saw h er alive on Nov. 16 1947

Immediate cause of death: Pulmonary Edema — Duration: 1 day

Due to:

Due to:

Other Conditions: Hodgkins Disease

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Robinson Jr. M. D.

Address Balto City Hosp Date signed 11-19-47

111c

G57034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. G57034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marguerite Besche

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fem.	White	Married

6 (b) Name of husband or wife Joseph F. Besche (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/80

8. AGE: Years	Months	Days	If less than one day
66	10	22	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Joseph F. Besche
(b) Address 1219 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Baltimore Highway

18 (a) Funeral director Braun Funeral Home
(b) Address 1216 S. Charles St.

19 NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1947 at 1:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 1947, to Nov. 16 1947, and that I last saw her alive on Nov. 15 1947.

Immediate cause of death: Bronchial pneumonia — Duration: 2 days
Due to Post-operative
Due to
Other Conditions Essential hypertension and chronic myocarditis — Duration: 8-10 years
(Include pregnancy within 3 months of death)
Date of operation Nov. 13, 1947
Major findings of operation: Large ventral hernia (suspain and ligature) Sac
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter B. Sanger, M.D.
Address Bon Secours Hospital Date signed 11/16/47

X

G57035 B-21944

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G57035
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 months
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs. 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Baltimore 22 Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7151 Holabird Ave. Balto 22.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MacFarland, Larry. (LARRY GUSTAV McFARLAND)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1945

8. AGE: Years 2 | Months 4 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John McFarland
13. Birthplace Maryland

MOTHER
14. Maiden Name Matilda Salkowski
15. Birthplace Maryland

16 (a) Informant Mrs. John McFarland
(b) Address 7151 Holabird Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/47 (month) (day) (year)
(c) Cemetery or crematory Christ Lutheran Ch. Cem.
Location Dundalk, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 NOV 18 1947 (b) [illegible] for Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1947 at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 15 1947 to NOV. 16 1947 and that I last saw him alive on NOV. 16 1947.

Immediate cause of death Cardio respiratory failure & meningitis — Duration

Due to Tuberculous meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Internal hydrocephalus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William B. Gorgas Jr. M. D.
Address South Balto. Gen. Hosp. Date signed 11/17/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

G57036 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S.Marine Hospital 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 das.
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 S.Broadway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GLENN, Robert Charles (ROBERT CHARLES GLENN)

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. 218-01-0026

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1893

8. AGE: Years	Months	Days	If less than one day
54	9	3	hr. min.

9. Birthplace Saganaw, Mich. (Town, county, and state)

10. Usual Occupation Night mate

11. Industry or business Seafaring business

FATHER
12. Name Charles Glenn
13. Birthplace Canada

MOTHER
14. Maiden Name Flora Nicholson
15. Birthplace Canada

16 (a) Informant Records
(b) Address U.S.Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1947, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3, 1947 to Nov.15, 1947, and that I last saw him alive on Nov. 15, 1947.

	Duration
Immediate cause of death: Acute pancreatic necrosis and acute peritonitis	11 days
Due to: Other conditions: Peri-hepatic abscess, chronic	unk
Due to: Hepatitis, infectious, regenerative stage	unk
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 11/5/47
Major findings of operation: Stenosis of common bile duct due pressure - Abscess of liver
If autopsy [redacted]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address U.S. Marine Hospital Date signed 11/17/47

G57037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45c

Registered No. G57037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1634 E 32nd St.
(c) Hospital or institution: 9.6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 E 32nd ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRIETTA VOLLERTHUM

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEM.	WHITE	WIDOW

6 (b) Name of husband or wife CHAS. VOLLERTHUM
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) JAN-16-186

8. AGE: Years	Months	Days	If less than one day
84	9 10	0	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business —

FATHER
12. Name ? DIETRICH.
13. Birthplace GERMANY.

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace

16 (a) Informant MR ARTHUR VOLLERTHUM
(b) Address 2542 W LAFAYETTE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 19-47 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN CEM
Location WOODLAWN MD

18 (a) Funeral director Mrs Chas A J Rohde
(b) Address 2327 Edmondson AVE

19 (a) NOV 18 1947 (Date received by Registrar) (b) Registrar Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 16 1947 at 4:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to NOV 16 1947 and that I last saw her alive on NOV 14 1947

Immediate cause of death	Duration
(a) Cerebral hemorrhage	
Due to (b) Cancer of mouth -	1/2/47
Due to (c)	
Other Conditions Arterial hypertension arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation was treated with radium
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis H. Krumrein M. D.
Address 222 No. Howard Date signed NOV 17 1947

G57038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G57038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Hoeven Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN RUSSELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name James Russell
13. Birthplace Md

MOTHER
14. Maiden Name Mary Angel
15. Birthplace Md

16 (a) Informant Mrs. Lillian Churchill
(b) Address 464 Maine St. Ind. Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19th 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount-Aliceanna

18 (a) Funeral director Leo G. Leach
(b) Address 702 N. Patterson Park

19 (a) NOV 18 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16/47 19..... at 5P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Hrs death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 11/17/47

G57039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170

G57039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 8-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 East North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael F. Kelley

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-16-8033

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Marcella Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1885

8. AGE: Years	Months	Days	If less than one day
62	3 2	12 11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Baltimore City

MOTHER | FATHER

12. Name Michael Kelly

13. Birthplace Ireland

14. Maiden Name Bridget Ward

15. Birthplace Ireland

16 (a) Informant John Kelly, brother

(b) Address 2302 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19, 1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cemetery

Location 4300 Old Frederick Rd

18 (a) Funeral director Edward W. Coughlin Son

(b) Address 924 E. Eager St.

19 (a) NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

45

20. DATE OF DEATH November 16, 1947 at 3 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull; Intracranial Hemorrhage; Compound Comminuted Fracture, all leg bones; Fractured ribs, Bilateral Hemothorax

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 8/6

(a) Date of injury 11-16-47 at 2 20 A. M.

(b) Where did injury occur? North Ave. 25' east of Rutland Avenue

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian struck by car

23. Signature Howard J. Mercer M.D. Medical Examiner.

Date signed 11/17/47

G5704 Devero

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G57040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 Park Ave.
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katie Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Willie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Old Age Pension

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Nov 18 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1947, to Nov 12 1947, and that I last saw h Sr alive on 11/12/47 19

Immediate cause of death	Duration
Myocarditis	
Due to Arteriosclerosis	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nellie F. Thomas, M.D.
Address 1625 Edmondson Ave. Date signed 11/14/47

X

G57041 3C 4-06855

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G57041

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address HARFORD ROAD & HERRING RUN
(c) Hospital or institution: SYDENHAM HOSPITAL 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 W. HAFFMAN (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME FRANK TURNER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	COLORED	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 27, 1944

8. AGE: Years	Months	Days	If less than one day
3	3	21	hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name ALEXANDER TURNER
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name MAGGIE WILSON
15. Birthplace NORTH CAROLINA

16 (a) Informant ALEXANDER TURNER
(b) Address 211 W. HOFFMAN ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Clay Hill, Md.

18 (a) Funeral director Wm. Halstead
(b) Address 918 Druid Hill Ave.

19 NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 17 1947, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 15 NOV 1947 to 17 NOV 1947 and that I last saw him alive on 16 NOV. 1947

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to ENCEPHALITIS	3 days
Due to PERTUSSIS	4 weeks
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward D. Capps M. D.
Address Sydenham Hospital Date signed Nov. 17, 1947

G57042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G57042

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonsville Pike
(c) Hospital or institution: Saint Agnes 28-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 Fork Ellicott Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Thomas Grieves

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife Evelyn Achsah Grieves
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/2/69

8. AGE: Years	Months	Days	If less than one day
78	4	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name David Grieves
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Owens
15. Birthplace Maryland

16 (a) Informant Mr. W. O. Grieves son
(b) Address 62 Market Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17/1947, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16/1947, to 11/17/1947, and that I last saw h[illegible] alive on 11/13/1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic cardiovascular disease	
Due to	
Other Conditions Diabetis mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jose G. Calderon M. D.
Address Date signed 11-17-47

VS 150

937

G57043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered G57043

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Paul & 32nd Sts.
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Paul & 32nd Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRANO Van WILLIAMS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ella G. Van Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1864

8. AGE: Years	Months	Days	If less than one day
83	3	24	hr. min.

9. Birthplace Zenith, N.Y.
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name John Van Williams
13. Birthplace N.Y.

MOTHER
14. Maiden Name Rachel Van Gaspeak
15. Birthplace N.Y.

16 (a) Informant Mr. Viron Van Williams
(b) Address 3217 Guilford Ave.

17 (a) Cremation (b) Date thereof 11/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 18 1947
(Date rec'd by registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 19 47 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947, to Nov 1947 and that I last saw [illegible] alive on Nov 16 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular disease	
Due to	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William S. Skipsch M. D.
Address 506 Roland Ave Date signed Nov 17 47

93D

G57044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937 ✓

Registered No. G57044

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2826 W. North Ave.
(c) Hospital or institution: 56
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2826 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARTIN MARSHALL

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Lottie May Marshall (nee Roberts) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1875

8. AGE: Years	Months	Days	If less than one day
71	10	21	hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Levin Marshall
13. Birthplace Cambridge, Md.

MOTHER 14. Maiden Name Caroline Wheatley
15. Birthplace Cambridge, Md.

16 (a) Informant Mr. Guy P. Marshall
(b) Address 2826 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1947 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1947, to Nov. 19, 1947 and that I last saw him alive on Nov. 16, 1947

Immediate cause of death	Duration
Arteriosclerosis	2 yrs.
Due to Chronic myo carditis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Williams M. D.
Address 2757 W. North Ave. Date signed 11/18/47

X

G57045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G57045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 28-W
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4107 Maine Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Esther Lisansky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Dared

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Bruna
15. Birthplace Russia

16 (a) Informant Mrs Barnard Livingston
(b) Address 4107 Maine Ave

17 (a) Burial (b) Date thereof 11-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Tefiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) NOV 18 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1947, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17 1947, to 11-17 1947, and that I last saw her alive on 11-17 1947.

Immediate cause of death	Duration
(a) Acute Myocardial Infarction	
Due to Coronary occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature C B Pearce M. D.
Address Univ Hosp Date signed 11-17-47

X

G57046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G57046

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 Shell Bank Rd
(c) Hospital or institution: 25

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Cherry Hill Project Balto Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Shell Bank Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Pulley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William Pulley,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 28, 1891

8. AGE: Years: 56 | Months: 7 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.,
(Town, county, and state)

10. Usual Occupation: Janitress,

11. Industry or business

FATHER
12. Name: John H. Brown.
13. Birthplace: Balto. Md.,

MOTHER
14. Maiden Name: Mary Medley
15. Birthplace: St. Marys Co. Md.

16 (a) Informant: Donalind Graham
(b) Address: Cherry Hill Project

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 19, 1947 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral,

Location

18 (a) Funeral director: McKatie R. Williams

(b) Address: 322 N. Schroeder St

19 NOV 18 1947 (Date rec'd by registrar) (Signature for Williams)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 15 19 47, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 19 47, to Nov. 15 19 47, and that I last saw h alive on Nov. 15 19 47.

Immediate cause of death	Duration
(a) Coronary Thrombosis	3 mos
Due to (b) Hypertension	
Due to (c) Cerebral Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: R. W. Reckling

Address 1 E. N. Avon St Date signed 11/18/47 M. D.

VS 150

R. W. Reckling - M.D.

G57047

225115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G57047

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 N. Gilmor, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alverta Holliday.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife William Holliday

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 1895

8. AGE: Years	Months	Days	If less than one day
52	6		hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19 1947 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St
NOV 18 1947 (Date rec'd by registrar) Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 15 - 1947 at 5-20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5- 1947 to 11-15- 1947 and that I last saw her alive on 11-15- 1947

Immediate cause of death: Myocardial Infarction — Duration: 15 Days
Due to: Sclerosis of Coronary artery
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Grob M. D.
Address J H H Date signed 15 Nov 47

X

G57048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

Registered No. G57048

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1141 W. Saratoga St.
(c) Hospital or institution: 9-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1141 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susie Turner.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Jessy Turner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25, 1886

8. AGE: Years 60 | Months 10 | Days 20 | If less than one day: hr. min.

9. Birthplace Accomac County, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Vaughan
13. Birthplace Virginia

MOTHER
14. Maiden Name Tester
15. Birthplace Virginia

16 (a) Informant Mary Jones.
(b) Address 1141 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18 - 1947. (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Schroeder St.

19 NOV 18 1947 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1947, at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1947 to Nov 14 1947 and that I last saw h[illegible] alive on Nov 13 1947

Immediate cause of death: Acute Cardiac Failure
Due to: Chronic Myocarditis
Due to: Chronic Pyelonephritis
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. S. Howell M.D.
Address 617 N. Carrollton Ave Date signed 11/25/47

G57049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G57049

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 N. Mount Street
(c) Hospital or institution: 14-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 N. Mount Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Johnson Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 12, 1876

8. AGE: Years	Months	Days	If less than one day
71 yrs.	2	2	hr. min.

9. Birthplace Essex County, VA. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Preston Gresham
13. Birthplace Essex County, VA.

MOTHER
14. Maiden Name Lucy Meade
15. Birthplace Tappahanna, VA

16 (a) Informant MATTIE Bell
(b) Address 1637 Edmondson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19, 1947 (month) (day) (year)
(c) Cemetery or crematory New Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) NOV 20 1947 W Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1947, at 10:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1947, to 11-14 1947, and that I last saw her alive on Nov. 14, 1947

Immediate cause of death	Duration
Pulmonary Congestion	3 days
Due to Lobar Pneumonia	9 days
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 W. Franklin St. Date signed 12-15-47

VS 150

G57050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G57050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 N. Eden St
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTo
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 N. Eden ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DELLA LOVEDAY

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1878

8. AGE: Years	Months	Days	If less than one day
65	4	6	hr. min.

9. Birthplace BALTO; Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name ?
13. Birthplace Md

MOTHER
14. Maiden Name Louisa ?
15. Birthplace Md

16 (a) Informant Charles Loveday
(b) Address 623 Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location B. C. County, Md

18 (a) Funeral director Joseph B. Lo[illegible]
(b) Address 1364 N. Central Ave

19 [illegible] (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16 1947, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1946, to 11-16 1947, and that I last saw h[illegible] alive on 11-16 1947

Immediate cause of death	Duration
Coronary Thrombosis	2 months
Due to chronic Myocarditis	7 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Wm Howard M. D.
Address 307 N. Caroline Date signed 11-18-47

VS 150

G57051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G57051

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 N. Bond Street

(c) Hospital or institution: 8-6

(d) Length of stay in hospital or inst. (yrs., mos., or days) None

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1514 N. Bond Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Elizabeth Estelle Hinkleman

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julius F. Hinkleman

6 (c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.) Jan. 29th., 1897

8. AGE: Years 50 | Months 9 | Days 19 | If less than one day: ####### hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name O'Donnell

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Elizabeth Geissler

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Julius F. Hinkleman

(b) Address 1514 N. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 (a) NOV 18 1947 (Rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH 11/17/47 19____, at 3:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1947 to Nov 17 1947, and that I last saw h[illegible] alive on Nov 16 1947.

Immediate cause of death	Duration
Broncho Pneumonia	6 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jacob Freiburg M. D.

Address 1873 N. Mast. Dr. Date signed 11/18/47

V S 150

057052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 057052

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in the causes of death clearly and legibly. Give correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 N Robenson St
(c) Hospital or institution: 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 N Robenson St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Kues (Myrtle E. Kues)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Casper Kues

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Jan. 27th., 1894

8. AGE: Years 53 | Months 9 | Days 20 | If less than one day ######## hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Eugine Clemens
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Casper Kues (Husband)
(b) Address 307 N. Robinson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location E. North Ave., Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1947 at 10 00 A.M.

21. I certify that I took charge of the remains described above, held an Aug Ed Insp thereon and from the evidence obtained (Autopsy / Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Kefauver M.D. Medical Examiner.
Date signed Nov 16, 1947

VS 151

G57053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G57053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1822 Bank Street
(c) Hospital or institution: 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 Bank Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH JAWORSKI

3 (b) If veteran, name war ****

3 (c) Social Security Account No. 218-09-8442

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) February 17, 1882

8. AGE: Years	Months	Days	If less than one day
65	8	29	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Nicholas Jaworski
13. Birthplace Poland

MOTHER
14. Maiden Name Rosé Krystofiak
15. Birthplace Poland

16 (a) Informant Mrs. Mary Jaworski
(b) Address 1822 Bank Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M.F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 NOV 18 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1947, at 1.57 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1947, to Nov 16 1947, and that I last saw h m alive on Nov 16 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Coronary Insufficiency	
Due to Myocardial degeneration	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. F. Ries M. D.
Address 24 S. Broadway Date signed Nov 17/47

VS 150

G57054 Singewald

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G57054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1624 Darley Avenue

(c) Hospital or institution: 8.5

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1624 Darley Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Lurz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret C. Lurz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1883

8. AGE: Years	Months	Days	If less than one day
63	11	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation P.O. Dept.

11. Industry or business

FATHER
12. Name Frank A. Lurz
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Margaret Lurz
(b) Address 1624 Darley Avenue

17 (a) Burial (b) Date thereof 11-19-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) NOV 19 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Nov. 15th, 1947, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3, 1947 to Nov. 15, 1947 and that I last saw h. im alive on Nov. 13, 1947.

Immediate cause of death	Duration
Auricular Fibrillation	5 Mos.
Due to Mitral stenosis & Aortic regurgitation	5 Mos.
Due to	
Other Conditions Passive congestion of liver. (Include pregnancy within 3 months of death)	2 Mos.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert L. Singewald

Address 1613 E. North Ave. Date signed 11-19-47

VS 150

G57055 Dr. Brennan

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5007 Walther Blvd.

(c) Hospital or institution: 27-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5007 Walther Blvd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Wooden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William Wooden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER

12. Name George Leach

13. Birthplace Md.

MOTHER

14. Maiden Name Marthat A. Shields

15. Birthplace Md.

16 (a) Informant Mr. Charles J. Tauber

(b) Address 5007 Walther Blvd.

17 (a) Burial (b) Date thereof 11-20-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road, 14

19 (a) (b)
(Date received by Registrar) (Registrar)

NOV 18 Remington Hollins, M.D.

VS 150-

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Nov 1947, and that I last saw her alive on Nov 16 1947

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertension w/ Cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Thomas J Brennan M. D.

Address 5217 Harford Rd Date signed 11-18-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G57056

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green Sts

(c) Hospital or institution: University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Howard

(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)

(d) Street No. Fells Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Jasper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27 1864

8. AGE: Years 83 | Months 10 | Days 17 | If less than one day hr. 19 min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name James Cooney

13. Birthplace Md

MOTHER

14. Maiden Name unknown

15. Birthplace Md

16 (a) Informant Robert J French

(b) Address 901 Old Oak Rd Woodbrook

17 (a) Burial (b) Date thereof 11-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md

18 (a) Funeral director H C Ivy suborhom

(b) Address Ellicott City Md

19 (a) NOV 18 1947 (registrar) (b) Huntington Hollins Md (registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/15 1947 at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1947 to 11/15 1947, and that I last saw h EE alive on 11/15 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 11/15

VS 150

X

G57057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓124a

G57057 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Erase, alter, or add nothing. Be sure to write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Annapolis Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WOODROW SHERMAN A TURNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-16-3654

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Valey M Turner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1913

8. AGE: Years	Months	Days	If less than one day
34	3	24	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laundry Worker
11. Industry or business

FATHER 12. Name Sherman Turner
13. Birthplace Va

MOTHER 14. Maiden Name Sadie Paige
15. Birthplace Va

16 (a) Informant Sherman Turner
(b) Address 2310 Annapolis Ave Bolts 30

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-47 (month) (day) (year)
(c) Cemetery or crematory Chantilly
Location Chantilly Va.

18 (a) Funeral director H C Brumbaugh Sons
(b) Address Ellicott City Md

19 NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1947, at 4.30 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH acute Congestive Cardiac Failure

Due to

Other Conditions Chronic Glomerulo nephritis Coleifestitis, acute alcoholism. Fatty liver.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 11-17-47

93E

57058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C57058

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 947 Penna. Ave.
(c) Hospital or institution: 17-W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 947 Penna. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Noah Peace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Phillip McCulloh
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Johnson
15 Birthplace Md.

16 (a) Informant Mr. Leon Johnson
(b) Address 2027 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St

19 (a) NOV 18 1947 (Date received by Registrar) (b) Huntington Williamsport, Md.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1947, at 1 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-17 1947, to 11-16 1947, and that I last saw h alive on 19

Immediate cause of death	Duration
Cardiac Insufficiency	2 dys
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 2 W Penna Ave Date signed 11-18-47

G57059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 D

G57059 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 39 South Curley Street
(c) Hospital or institution: None 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 39 South Curley Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE E. (WEISCHERT) Weichert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John T. (Weischert) Weichert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 23, 1900

8. AGE: Years	Months	Days	If less than one day
46	11	23	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Joseph Smythe
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Jones
15. Birthplace Maryland

16 (a) Informant John T. (Weischert) (husband) Weichert
(b) Address 39 South Curley Street

17 (a) Burial (b) Date thereof 11-19-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem
Location Frederick Avenue

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe Street

NOV 19 1947 (Date rec'd by Registrar) (Huntington Williams, M.D.)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1947, at 5:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1947 to Nov. 15 1947. and that I last saw h[illegible] alive on Nov. 14 1947

Immediate cause of death	Duration
Carcinoma of Uterus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Andrew Kurosaki M. D.
Address 3529 Eastern Av. Date signed 11/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓46 B

G57060 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1845 W. Lexington St.
(c) Hospital or institution: 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1845 W. Lexington St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen M. McTague

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Patrick F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1870

8. AGE: Years	Months	Days	If less than one day
77	1	21	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Slattery
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Cunningham
15. Birthplace Ireland

16 (a) Informant Mike Kiernan
(b) Address 1845 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-47 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fort Avenue & Fayette St.

19 (a) Registrar (b) Date received NOV 18 1947 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1947, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1945, to 11/16 1947, and that I last saw him alive on 11/16 1947.

Immediate cause of death	Duration
Myocardial degeneration	2 days.
Due to Arteriosclerosis	?
Due to Diabetes Mellitus	?
Other Conditions Carcinoma of stomach?	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature Samuel E. Bogard
Address 1905 W. Baltimore Date signed 11/18/47

61

G57061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

G57061
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Baltimore Gen. Hosp.
(c) Hospital or institution: 24-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James M.E. BORKOSKI

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-3210

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Clara Borkoski
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) 1/27/1903

8. AGE: Years	Months	Days	If less than one day
44	9	20	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Stanislaus Borkoski
13. Birthplace Poland

MOTHER
14. Maiden Name Angela Parcinska
15. Birthplace Poland

16 (a) Informant Clara Borkoski
(b) Address 1622 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Balto. Co.

18 (a) Funeral director Charles J. Dill
(b) Address 1501 E. Fort Ave

19 (a) NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1947 at 11:45 a.m.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Give the causes of death clearly and legibly. correct age is especially important. Physicians: please write the c

G57062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

G57062 Registered No.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4714 Vessel Court
(c) Hospital or institution: 75

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City of Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4714 Vessel Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Lowry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, ~~married~~, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ Robert K Lowry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13 1856

8. AGE: Years 91 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace York Co. Penna (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph P. Wiley
13. Birthplace York Co Penna

MOTHER 14. Maiden Name Elizabeth Donnan
15. Birthplace York Co Penna

16 (a) Informant Robert K Lowry
(b) Address 4714 Vessel Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Greenmount & Oliver St

18 (a) Funeral director William Cook Inc
(b) Address 1912 St. Paul St. Balto Md.

19 (a) NOV 18 1947 (b) Huntington Pathological Lab. (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1947 at 5:45 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Wolbach M.D.
Medical Examiner.
Date signed Nov 18, 1947

G57063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Register No. G57063

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 S. Fagley St.,
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 S. Fagley St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Johanna Storm

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Stophel Storm
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1862

8. AGE: Years	Months	Days	If less than one day
85	10	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Joseph Utz
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Gilbert Schepleng
(b) Address 511 N. Highland Ave.,

17 (a) Burial (b) Date thereof 11/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) NOV 18 1947 Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 16, 1947 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1947 to Nov 15 1947 and that I last saw h-r alive on Nov 10 1947

Immediate cause of death	Duration
Acute Cardiac Dilatation	3 days
Due to Chronic Cardio Vascular Disease	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael A. Hoare M. D.
Address 1820 Eutaw place Date signed Nov. 17 1947

X

G57064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57064

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Be sure to state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3637 Roberts Place
(c) Hospital or institution: 26th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ~~Balto Co~~
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3637 Roberts Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley R. Mohler

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife Mary L. Mohler
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feby 24 1887

8. AGE: Years	Months	Days	If less than one day
60	8	18	hr. min.

9. Birthplace Martinsburg Va
(Town, county, and state)
10. Usual Occupation Pipe Fitter
11. Industry or business Sparrows Pt

FATHER
12. Name Hubert B. Mohler
13. Birthplace Va

MOTHER
14. Maiden Name Dont Know
15. Birthplace

16 (a) Informant Mrs Mary Mohler
(b) Address 3637 Roberts Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18th 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2206 Orleans St

19 (a) NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16th 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1947 to Nov. 16 1947 and that I last saw him alive on Nov. 16 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Chronic Myocarditis	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Joseph Tawney
Address 441 S. Ellwood Ave Date signed 11/19/47

VS 150

Med. Dr Case
G57065 ed to Hosp

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77E

Registered No. G57065

*PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abraham Neblett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1904

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER 12. Name Monroe Neblett

13. Birthplace Va

MOTHER 14. Maiden Name Emmie Williams

15. Birthplace Va

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 11-20-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. Co.

18 (a) Funeral director Byron T. Morris W. Wright

(b) Address 321 Augusta St.

19 NOV 18 1947 (Date rec'd by Registrar) (b) Huntington Ave Baltimore, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1947 at 6 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1947 to Nov 16 1947 and that I last saw him alive on Nov 16 1947

	Duration
Immediate cause of death: Intoxication ? denatured alcohol	unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp Date signed 18 Nov 47

VS 150

11/18/47 Howard J. Andrews, M. D.
X

Eber G. Nesbitt

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 57066

57066

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil
(c) City or town Port Deposit (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eber G. Nesbitt

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-7969

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 7-8-1880

8. AGE: Years 67 | Months 4 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Port Deposit, Md (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name George W. Nesbitt

13. Birthplace Penna

MOTHER 14. Maiden Name Margaret Archibald

15. Birthplace Port Deposit, Md

16 (a) Informant Margaret Nesbitt

(b) Address Mercy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21 1947 (month) (day) (year)

(c) Cemetery or crematory Harmony Chapel

Location Rowlandville, Cecil Co. Md

18 (a) Funeral director Lee A. Patterson & Son

(b) Address Perryville, Md

19 NOV 18 1947 (b) (Accepted by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18- 1947, at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1947, to 11-18 1947, and that I last saw h. alive on 11-18 1947.

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis

Due to Senile Brain Disease

Other Conditions Duodenal Ulcer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams, M.D.
Address Mercy
Date signed 11-19-47

VS 150

G57067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 112

Registered No. G57067

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 N. Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Melvin Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Generett
13. Birthplace S-C

MOTHER
14. Maiden Name Anna McCree
15. Birthplace S C.

16 (a) Informant Cornelia Generett
(b) Address 1335 Penna. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Sandy Grove
Location North Carolina

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

19 (a) NOV 18 1947 (Registered by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1947, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1947 to 11/17 1947 and that I last saw h.c.r. alive on 11/17 1947.

Immediate cause of death	Duration
Respiratory Collapse	
Due to Bronchial Asthma.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. N. Taylor M. D.
Address Univ. Hospital Date signed 11/18/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

557068 B.C.H. V-93900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 557068

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner and Dukeland St.
(c) Hospital or institution:
West Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 min
(e) Length of stay in Baltimore (yrs., mos., or days) 14 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel Co.
(c) City or town Lemmon Park, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Whitmans Landing
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Woebenhuss

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/13/47

8. AGE: Years	Months	Days	If less than one day
			hr. 14 min.

9. Birthplace Balt. Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Paul H. Woebenhuss
13. Birthplace Anne Arundel County

MOTHER 14. Maiden Name Marion Hyatt
15. Birthplace Jamaica, Long Island, New York

16 (a) Informant Daisy Woebenhuss
(b) Address Lemmon Park, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or Crematory Johns Hopkins Medical School NOV 1947
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 NOV 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13/47 19 to 11/13/47 19 , and that I last saw h[illegible] alive on 11/13/47 19

Immediate cause of death	Duration
Respiratory failure	
Due to Intracranial hemorrhage	
Due to (1) Forceps application Single (2) Fracture by	
Other Conditions Brute Force	

(Include pregnancy within 3 months of death)
Date of operation 11/13/47
Major findings of operation: C.S.T.
ROP
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature GS Waldrop M.D.
Address WB 6 12 Date signed 11/18/47

VS 150

G57069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

G57069
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Schroeder St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Creola Johnson (Creolia Faison Johnson)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: N

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: David Faison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1905

8. AGE: Years 42 | Months 10 | Days | If less than one day: hr. min.

9. Birthplace Wheelersville, Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Thomas Johnson
13. Birthplace Wheelersville, Va.

MOTHER
14. Maiden Name Pauline Johnson
15. Birthplace Wheelersville, Va.

16 (a) Informant Annie Reed
(b) Address 922 N. Melrose St.

17 (a) Shipped (b) Date thereof Nov. 10 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Suffolk, Va.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 E. Jefferson St
Huntington Williams Mills Registrar

19 (a) NOV 8 1947 (b)
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14 1947 at 8 50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1947 to 11/14 1947 and that I last saw h.e.r alive on 11/14 1947

Immediate cause of death: Subarachnoid Hemorrhage → Duration: 16 days

Due to: Hypertension

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M.D.
Address 1514 Division Ave Date signed 11/15/47

X

G57070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G57070 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4126 Maribau Court 25
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4126 Maribau Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Rebecca Sell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Chester Arthur Sell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28-1884

8. AGE: Years 63 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Rowlesburg West Virginia (Town, county and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Charles B. Pugh
13. Birthplace West Virginia

MOTHER
14. Maiden Name Mary Ruth Lawson
15. Birthplace Frostburg Md.

16 (a) Informant Mrs. William F. Harrison
(b) Address 4126 Maribau Court

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Philos Cemetery
Location Westernport Md.

18 (a) Funeral director Charles George
(b) Address Cumberland Md.

19 (a) Dated (b) Registered by registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-16 1947, at 1:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1940 to Dec. 18 1940 and that I last saw h[illegible] alive on Dec. 16 1940

Immediate cause of death: Carcinoma of Sigmoid — Duration

Due to: Colon & Generalized Metastasis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo Luttrell M.D.

Address 320 Ontario Date signed 11/18/47

T20259

BALTIMORE CITY HEALTH DEPARTMENT G57071 Registered No.

CERTIFICATE OF DEATH 46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2635 Guilford Avenue
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 57 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2635 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country -----

3 (a) FULL NAME Mary Agnes Zimmisch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1889

8. AGE: Years	Months	Days	If less than one day
57	11 10	27	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Musician
11. Industry or business ------

FATHER
12. Name Charles Edward Zimmisch
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Theresa Hauf
15. Birthplace Philadelphia, Pa.

16 (a) Informant Mrs. L. H. Armstrong
(b) Address 5814 Kalloops Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 1345 N. Calvert Street

19 (a) NOV 19 (Date rec'd by registrar) (b) Hunting for Nathanie, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1947, at 5-20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1947 to Nov 17 1947 and that I last saw her alive on Nov 16 1947.

Immediate cause of death	Carcinoma of Colon	Duration
Due to		
Due to		
Other Conditions	Metastases to Lungs	

(Include pregnancy within three months of death)

Date of operation Sept 1947
Major findings of operation Carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank J. Geraghty M.D.
Address 3041 St Paul St Date signed 11/18/47

G57072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G57072 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2516 Maryland Ave
(c) Hospital or institution: 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2516 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Bear Middleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name David
13. Birthplace Austria

MOTHER
14. Maiden Name Sarah
15. Birthplace Austria

16 (a) Informant Clara Middleman
(b) Address 2516 Maryland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Rogers Ave

18 (a) Funeral director Jacob Lewis Inc
(b) Address 2400 Eastern Ave, Baltimore, Md.

19 (a) NOV 19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-1947, at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to Nov. 18 1947. and that I last saw h. alive on Oct. 25 1947.

Immediate cause of death	Duration
Coronary Occlusion	1 min.
Due to Arteriosclerosis	20 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Herbert Goldstone M. D.
Address 2215 Linden Ave. Date signed Nov. 18, 1947

V S 150

G57073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G57073 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered, or "unknown" or "none" inserted where necessary. Do not use abbreviations or ditto marks. Be sure to write the causes of death clearly and legibly. Use only one line for each cause. Do not enter more than one cause unless required by the physician. Be sure that the correct age is especially important. Physicians: please write your name and address plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 N.Collington Avenue
(c) Hospital or institution: None 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 N.Collington Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country – – – –

3 (a) FULL NAME SUSAN LOTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) June 5, 1879

8. AGE: Years	Months	Days	If less than one day
68	5	13	....hr. ....min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business Domestic

FATHER
12. Name Michael Lotz
13. Birthplace Germany

MOTHER
14. Maiden Name Susanna Schwartzkopf
15. Birthplace ?

16 (a) Informant Miss Catherine Volkman
(b) Address 615 N.Collington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe Street.

19 (a) NOV – 5 (Date rec'd by registrar) (b) Functing for Baltimore, Md. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1947, at 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Nov 18 1947, and that I last saw h[illegible] alive on [illegible] 1947.

Immediate cause of death	Duration
Hypertension	7 yrs
Due to Cardio	
Due to Uraemia	
Other Conditions Uterus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred Deitz Sr M.D.
Address 600 N Collington Ave Date signed Nov 19 47

G57074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G57074

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2222 Mt Holly St
(c) Hospital or institution: 15-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Mc Namara

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Herbert McNamara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 5, 1877

8. AGE: Years: 70 | Months: 3 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Zieget
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Mildred Ayd
(b) Address: 2222 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Received NOV 19 1947 Balto., Md.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1947, at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cormary Artery Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 11/17/47

657075 BALTIMORE CITY HEALTH DEPARTMENT 657075

CERTIFICATE OF DEATH 127a

Registered No.

1. PLACE OF DEATH: Union Memorial Hospital
(a) Baltimore City, Maryland
(b) Street address 603 Greenway Apts.
(c) Hospital or institution: Union Memorial Hospital 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore #18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Greenway Apts 34th of Charles St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted]. Wright (Charlotte M.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Mr. Fred A. Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 October 1868

8. AGE: Years 79 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Maine (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James A. Lockhart
13. Birthplace Canada

MOTHER
14. Maiden Name Eva Mills
15. Birthplace Maine

16 (a) Informant Mrs. Charles F. Gardner
(b) Address 1521 Parkhill Rd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov. 19, 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 19 1947 (Date rec'd by registrar) (b) Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 November 19 47, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19

	Duration
Immediate cause of death: Pulmonary Embolism	
Due to: Acute Coronary Thrombosis	
Due to: Arteriosclerosis	
Other Conditions: Subphrenic abscess with partial intestinal obstruction, Acute gangrenous cholecystitis	

(Include pregnancy within 3 months of death)

Date of operation 10/3/47

Major findings of operation: Acute gangrenous cholecystitis

of autopsy: Pulmonary embolism

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Parker Richard Brown M. D.
Address Union Memorial Hosp. Date signed 11/19/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

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G57076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G57076

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in permanent ink. Do not use pencil. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y (b) County
(c) City or town Richmond Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. 108-05 95th Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eda Mae Lonsdale

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife 9-16-26

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-16-26

8. AGE: Years	Months	Days	If less than one day
21	3	2	hr. min.

9. Birthplace Brooklyn N. Y (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Lonsdale
13. Birthplace NY Brooklyn

MOTHER
14. Maiden Name Ruth Caney
15. Birthplace NY.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cem
Location Brooklyn, N.Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md

19 (a) NOV 19 1947 (b) Washington Willis Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1947 at 3 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1947 to Nov 18 1947 and that I last saw her alive on Nov 18 1947

	Duration
Immediate cause of death Hemorrhagic Shock	30 hrs
Due to Generalized bleeding tendency	?
Due to	
Other Conditions Totalogy of Fallot Life Subclavian - Pulmonary anas (Important conditions contributing to death but not related to immediate cause of death. Operation or pregnancy within 3 months of death)	

Date of operation
Major findings of operation: Totalogy of Fallot
of autopsy: Hemorrhagic pericardium Hemothorax Hemoperitoneum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Cleary
Address Johns Hopkins Hosp Date signed 11-18-47

X

057077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 057077

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Weitzel Avenue
(c) Hospital or institution: 27-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4515 Weitzel Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES EDWIN SLOVER

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-14-2482

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Emma C. Slover
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1855

8. AGE: Years	Months	Days	If less than one day
92 93	5	21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Patapsco Dry Dock

FATHER
12. Name James T. Slover
13. Birthplace Connecticut

MOTHER
14. Maiden Name Sarah Hopkins
15. Birthplace Maryland

16 (a) Informant Mrs. A.R. Ashburn
(b) Address 4515 Weitzel Avenue -14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 NOV 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH November 17 1947, at 8.12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1935 to 11-17 1947 and that I last saw him alive on 11-17 1947.

Immediate cause of death	Duration
Heart Block	1 day
Stokes-Adams Syndrome	
Due to Chronic Myocarditis	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.W. Peake M. D.
Address 4505 Harford Rd Date signed 11-18-47

V S 150

57078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G57078

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Frederick Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George R. Hodges (GEORGE RINGGOLD HODGES)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-05-4379

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Elizabeth E. Hodges

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1875

8. AGE: Years 71 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Maintenance man

11. Industry or business: Armistead Gardens

FATHER
12. Name: Samuel Hodges
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mary Medinger
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. John C. Fritz
(b) Address: 3042 Chesterfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/47 (month) (day) (year)

(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 NOV 19 1947 (Date rec'd by registrar) (b) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1947, at 1 45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Multiple fractures, Ruptured diaphragm, Ruptured liver, Ruptured spleen, Ruptured left kidney

DUE TO

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 20/2

(a) Date of injury 11-16-47 12 40 A. M.

(b) Where did injury occur? Baltimore St. near Warwick Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian struck by auto

23. Signature [signature] M.D.
Medical Examiner

Date signed 11-16-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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X

57079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Register No. 65079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4426 Kenwood Ave
(c) Hospital or institution: 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4426 Kenwood Ave (Rural give location)
(e) Citizen of foreign country? White (Yes or No)
If yes, name country

3 (a) **FULL NAME** Dennis J. Byrnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11 1884

8. AGE: Years 63 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Dennis J Byrnes
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Ireland

16 (a) Informant Bertha A. Byrnes
(b) Address 4426 Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Loretto Ave

18 (a) Funeral director John C Moran
(b) Address 3600 Baltimore Blvd

19 Date filed by Registrar Nov 19 1947 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1947 to Nov. 1947, and that I last saw h. alive on 11-16 1947

Immediate cause of death	Duration
Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C V Ewalt
Address 36 York Ct. Date signed 11-18-47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

57080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G57080

PLEASE WRITE PLAINLY, WITH UNFADING INK. Employ undertaker to report the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2114 W. Saratoga St
(c) Hospital or institution: ——— 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) ———
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2114 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER G HEERD

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-03-5292

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Edna N.
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) April 11 1894

8. AGE: Years 56 | Months 7 | Days 34 | If less than one day ——hr. ——min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Maintenance Man
11. Industry or business B. & O. R. R.

FATHER: 12. Name Charles H Heerd
13. Birthplace New York

MOTHER: 14. Maiden Name Haddie Daggae
15. Birthplace New York

16 (a) Informant Mrs. Edna N. Heerd
(b) Address 2114 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 19 Nov 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. B. Wippgal & Son
(b) Address 1300 Eutaw Place

19 NOV 19 1947 (Date rec'd by Registrar) (b) Evelyn for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15th 1947, at 8:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1947 to Nov. 15 1947, and that I last saw h. alive on Nov. 15 1947

Immediate cause of death Arteriosclerotic Cardio-Renal Vascular disease

	Duration
Due to	
Due to	
Other Conditions Coronary Thrombosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Elmer Laughlen M. D.
Address 400 N. Payson St. Date signed 11/20/47

VS 150

57081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 57081

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 30 S. Culver Street
(c) Hospital or institution: 20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 S. Culver Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas M. WESSEL

3 (b) If veteran, name war

3 (c) Social Security Account No. 216075178

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Leona

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30-1908

8. AGE: Years	Months	Days	If less than one day
39	3	28	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Credit Mgr.

11. Industry or business

FATHER
12. Name Thomas L. Wessel
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Budka
15. Birthplace Poland

16 (a) Informant Leona Wessel
(b) Address 30 S. Culver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 NOV 19 1947 (Date rec'd by registrar) (b) Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1947 at 8 A.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carbon monoxide poisoning.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-17-47 at A.M.
(b) Where did injury occur? 30 S. Culver Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhalation of illuminating gas

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11/17/47

VS 151

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G57082 BROWN ✓ G57082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write "unknown" unless necessary. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3137 N. Carrollton Ave
(c) Hospital or institution: 18.2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3137 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. divorced

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/4/1901

8. AGE: Years 46 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Painter
11. Industry or business

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/47 (month) (day) (year)
(c) Cemetery or crematory Henderson
Location Henderson N. C.

18 (a) Funeral director Reg. H. Pelson
(b) Address 1303 Pressman St

19 (a) (Date received by registrar) (b) Carrington-Williams Mort.

NOV 19 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1947 at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/47 to 11/17 1947 and that I last saw h— alive on 11/17 1947.

Immediate cause of death	Duration
Cerebral Apoplexy	5 D
Due to Hypertension Vascular Disease	2 Yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. D. Hatcher M.D.
Address 1715 Fairfax Date signed 11/18/47

X

G57083 114883

BALTIMORE CITY HEALTH DEPARTMENT ✓ G57083

CERTIFICATE OF DEATH .13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 890 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Henson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nannie Henson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15- 1882

8. AGE: Years 65 | Months 6 | Days 1 | If less than one day ....hr. ....min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joshua Henson
13. Birthplace Md.

MOTHER
14. Maiden Name Hannah ?
15. Birthplace Md.

16 (a) Informant B.C.H.Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11-20-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location G. A. Co, Maryland

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna, Ave

19 (a) (b)
(Date received by registrar) Registrar

NOV 19 1947
V S. 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16- 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1947 to Nov. 16 1947 and that I last saw him alive on Nov. 16 1947

Immediate cause of death	Duration
Pulmonary Tuberculosis, bilateral	5 mo's
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. C. Robinson Jr M. D.
Address Balt. City Hosp. Date signed 11/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this certificate must be answered. Where there is no correct answer write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G57084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

G57084 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Lexington St
(c) Hospital or institution: 18.2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 1901

8. AGE: Years	Months	Days	If less than one day
46	2		hr. min.

9. Birthplace S. C (Town, county, and state)

10. Usual Occupation H. W

11. Industry or business

FATHER
12. Name Ben Williams
13. Birthplace S. C.

MOTHER
14. Maiden Name Emma Shaw
15. Birthplace S. C.

16 (a) Informant James Williams
(b) Address 1101 Lexington

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Steplens
Location S. C.

18 (a) Funeral director Josiah L Brownson
(b) Address 1058 Montgomery St

19 (a) Nov 9 1947 (Local registrar) (b) Huntington for Mill Baltimore, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1947 at 8:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1947, to Nov 16 1947, and that I last saw h[illegible] alive on Nov 16 1947

Immediate cause of death	Duration
Cute Arachnoid Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Garland Shirell Jr. M. D.
Address 902 W. Franklin Date signed 11-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct. Certify the causes of death clearly and legibly. Underlining is especially important. Physicians: please write the correct age.

G57085 (1)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 131a

Registered No. G57085

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. #13 Box 444 H
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emer Heckman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3 - 1880

8. AGE: Years 67 | Months | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Nebraska
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Unk
13. Birthplace "

MOTHER
14. Maiden Name Unk
15. Birthplace "

16 (a) Informant Mrs Ina V. Streit
(b) Address R.D. #13 Box 444 H

17 (a) Burial (b) Date thereof 11-20-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Gr Rich & Highway

18 (a) Funeral director John J Emerick
(b) Address 414 Eastern Ave

19 (a) (b)
(Date work by registrar) Registrar

NOV 19 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17 1947, at 11:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1947 to 11/17 1947, and that I last saw him alive on 11/17 1947.

Immediate cause of death Cerebral Anoxemia — Duration

Due to Bronchopneumonia; — Duration

Due to Hypertensive arteriosclerotic cardiovascular renal disease — Duration

Other Conditions Old Left cerebral hemiplegia; R. Hemiplegia — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David D. Phillips M. D.
Address Univ. Hosp. Date signed 11/18/47

X

G57086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G57086

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 639 Harvey St.
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 639 Harvey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary S. Freburger
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife William C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16-1894

8. AGE: Years	Months	Days	If less than one day
53	6	0	hr. min.

9. Birthplace St. Mary's Co. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business House wife

FATHER
12. Name John Fenhagen
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Mary Cullison
15. Birthplace St. Mary's Co. Md.

16 (a) Informant William C. Freburger
(b) Address 639 Harvey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Flynn-Fleming
(b) Address 1426 Light St.

19 (a) NOV 19 1947 (Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16- 1947, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1947 to 11/16 1947, and that I last saw h.e. alive on 11/ 1947.

Immediate cause of death: Melano carcinoma — Duration: 3 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Max Bamm M.D.
Address 1501 N. Wilton Ave 13 Date signed 11/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Write the causes of death clearly and legibly. Omit abbreviations and correct age is especially important. Physicians: please write the

VS 150

G57087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G57087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Spell out full name and write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 8.6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Regester (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christopher Sponsel

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-4074

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Wht	Married

6 (b) Name of husband or wife: Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1873

8. AGE: Years	Months	Days	If less than one day
74	4	20	hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Tailor
11. Industry or business

FATHER
12. Name: John
13. Birthplace: Germany

MOTHER
14. Maiden Name: not known
15. Birthplace: Germany

16 (a) Informant: Wife
(b) Address: 1616 N. Regester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/47 (month) (day) (year)
(c) Cemetery or crematory: Immanuel
Location: Grindon Lane

18 (a) Funeral director: Clarence F. Hoffmann
(b) Address: 1639 Broadway.

19 NOV 19 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1947 at 7.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1947 to Nov 17 1947, and that I last saw him alive on Nov 17 1947.

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Congestive Heart Failure	
Due to Coronary Thrombosis Obstruction	
Other Conditions Bilateral inguinal hernias	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Nil

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Lee Posing Jr M. D.
Address: Redwood & Greene Sts Date signed 11/17/47

X

G57088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered G57088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2835 W. Garrison Ave
(c) Hospital or institution: 27-17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2835 W Garrison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Bernstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation News Stand

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Nettie Bernstein
(b) Address 2835 W Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 2180 Eutaw Place

19 (a) NOV 19 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-1947, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 AM Nov 18 1947, to 9 AM Nov 18 1947, and that I last saw him alive on Nov 18 1947.

	Duration
Immediate cause of death Probably Coronary Thrombosis	1 day
Due to Arteriosclerotic Heart Dis	8 yrs
Due to	
Other Conditions Paroxysmal auricular tachycardia (Include pregnancy within 3 months of death)	6 hrs ?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis A. Cohen
Address 5901 Park Heights Ave Date signed M. 11 D. 18 / 47

V S 150

G57089 B-Cath J-78816 ✓ G57089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered, or the word "unknown" or the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp. 26-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3056 Mayfield Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Stephanie Ann Sikorski

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 20, 1947

8. AGE: Years	Months	Days	If less than one day
	5	30	7 hr. 30 min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None (Infant)
11. Industry or business

FATHER
12. Name Stephen J. Sikorski
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ruth Deaver
15. Birthplace Balto. Md.

16 (a) Informant Ruth Deaver
(b) Address 3056 Mayfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-47 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address 3605 Harford Rd

19 (a) Date received by Registrar 11-19-1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1947, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1947, to Nov 19, 1947, and that I last saw her alive on Nov. 19, 1947

Immediate cause of death	Duration
Aspiration Pneumonia and atelectasis	12 hrs.
Due to Toxemia Paralytic ileus	3-4 days
Due to Peritonitis ← Postoperative	3-4 days
Other Conditions Retromammal Fistula, delayed	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Di Risa M. D.
Address Mercy Date signed 11-19-47

VS 150

X

G57090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G57090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. If unknown, write unknown. Do not abbreviate. In case of death from disease write the causes of death clearly and legibly. Physicians: please correct age if especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2520 W Mosher St
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 W Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary B McCullough
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 - 1883

8. AGE: Years	Months	Days	If less than one day
64	1	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Anthony Cook
13. Birthplace Baltimore

MOTHER 14. Maiden Name Elizabeth Miller
15. Birthplace Baltimore Md

16 (a) Informant Hebert McCullough
(b) Address 2520 W Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Chas P Powell
(b) Address 2407 Edmondson Ave

19 (a) Date signed NOV 19 1947 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1947, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 11, 1947, to Nov. 18, 1947, and that I last saw her alive on Nov. 17, 1947.

Immediate cause of death	Duration
Carcinoma - Bone & Pelvis, Pelvic Abdominal Viscera	
Due to Left Lung.	
Due to Left Mastectomy for Carcinoma 5 yrs ago.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 520 Medical Arts Bldg Date signed 11/19/47

G57091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63 B

Registered No. G57091

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: 11-2
St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.OA.
(e) Length of stay in Baltimore (yrs., mos., or days) 40years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ********
(c) City or town City of Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Latrobe Apts. - Charles & Read St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard (Harry) MILTON GROSS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife Sybilla Wiegand Gross
6 (c) If alive, give age ### years

7. Birth date of deceased (mo., day, yr.) JAN. 11, 1882

8. AGE: Years	Months	Days	If less than one day
65	10	7	hr. min.

9. Birthplace Baltimore County Md.
(Town, county, and state)
10. Usual Occupation Maintenance Engineer
11. Industry or business Pennsylvania Railroad

FATHER
12. Name John H. Gross
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline M. Kroeder
15. Birthplace Maryland

16 (a) Informant Mrs. J. W. Pierson (Sister-in-law)
(b) Address 1107 St. Paul Street, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave., Balto.

19 [illegible] 19 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1947, at 8:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1937, to Nov. 1947, and that I last saw him alive on Nov. 7 1947.

Immediate cause of death coronary occlusion — Duration 10 yrs.
Myocardial failure

Due to as a complication of
hyperthyroidism

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Pierson
Address 1107 St. Paul St Date signed Nov. 20, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G57092 BC# 47-9900 BALTIMORE CITY HEALTH DEPARTMENT G57092
CERTIFICATE OF DEATH 101 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 McKean Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Louis Thomas
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Child
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4-11-44
8. AGE: Years 3/12 | Months 4 6 | Days 7 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name Jesse Carl Thomas
FATHER 13. Birthplace N. Carolina
MOTHER 14. Maiden Name Bertha Alston
MOTHER 15. Birthplace N. Carolina

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Nov. 19 1947 (month) (day) (year)
(c) Cemetery or crematory David
Location Weldon, N. C.
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Rebecca St.
NOV 19 1947
19 (a) (Date rec'd by registrar) (b) Wilmington for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1947, at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 19 47 to Nov 18 19 47 and that I last saw h[illegible] M alive on Nov 16 19 47

Immediate cause of death Pneumothorax — Duration 4 mos.
Due to Chylothorax
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Aug 6, 1947
Major findings of operation: Chylothorax
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Kirkpatrick
Address Johns Hopkins Hosp. Date signed Nov 18, 1947

VS 150

X

G57093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8-3a

Registered No. G57093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Rawlins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	married

6 (b) Name of husband or wife Sadie Rawlins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1898

8. AGE: Years	Months	Days	If less than one day
49	9	4	hr. min.

9. Birthplace Wilson, N. C. (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Benjamin F. Rawlins
13. Birthplace Stovall, N. C.

MOTHER
14. Maiden Name Ella Westley
15. Birthplace Rocky Mount, N.C.

16 (a) Informant Sadie Rawlins
(b) Address 1531 Edmondson Ave

17 (a) Burial (b) Date thereof Nov. 20-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Hall
(b) Address 322 N. Schroeder St.

19 (a) (b)
(Date rec'd by registrar) Huntington Hill Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1947, at 11:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1947 to Nov 18 1947, and that I last saw h. alive on Nov 18 1947.

Immediate cause of death: respiratory failure — Duration
Due to: Subarachnoid hemorrhage
Due to:
Other Conditions: Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. C. Durrell Jr. M. D.
Address University Hosp Date signed Nov 19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

VS 150

G57094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G57094

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of the causes of death clearly and legibly. correct age is especially important. Physicians: please write the c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1322 N. Mount Street
(c) Hospital or institution: 152
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 N. Mount Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SUSIE F. DORSEY

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 17, 1871

8. AGE: Years 76 | Months 7 5 | Days 0 | If less than one-day ____hr. ____min.

9. Birthplace Howard County, Md. (Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name Dennis Addison
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Addison
15. Birthplace Maryland

16 (a) Informant Joseph Hill
(b) Address 1922 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

19 NOV 19 1947 (Date received by registrar) (b) Registered by [illegible] Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17-1947 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11-1947 to 11-17-1947 and that I last saw h. alive on 11-16-1947

Immediate cause of death Chronic valvular disease of heart — Duration 2 yrs 4 mos

Due to

Due to

Other Conditions Arterio Sclerosis — 15 months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. I. Campbell M. D.
Address 629 N. Carey St Date signed 11-19-47

G57095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G57095 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 S. Poppleton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 S. Poppleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julian Kemp McCauley

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 365-12-3668

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1901

8. AGE: Years 45 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Guilford Co., N. C. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business Ore Steamship Co.

FATHER
12. Name John Berry McCauley
13. Birthplace N.C.

MOTHER
14. Maiden Name Marticia Bradshaw
15. Birthplace N.C.

16 (a) Informant Hanes Funeral Home
(b) Address Greensboro, N.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/20/47 (month) (day) (year)
(c) Cemetery or crematory
Location Greensboro, N.C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

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correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1947, 11 AM

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions Acute dilatation of heart
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Kelly M.D.
Medical Examiner.
Date signed 11-19-47

G57096 BALTIMORE CITY HEALTH DEPARTMENT G57096

CERTIFICATE OF DEATH 1947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Smith, George E

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Lucy Mae Smith
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) October 26 1876

8. AGE: Years 70 | Months 1 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Node
11. Industry or business -

FATHER
12. Name Smith, Geo.
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Smith, John - (Son)
(b) Address Bethill Beach-Pasadena Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 '47 (month) (day) (year)
(c) Cemetery or crematory Saint Michaels
Location Ridge Md

18 (a) Funeral director Thomas L. Kenny Inc
(b) Address Wallis & Gilmor Sts

19 (a) NOV (Date received) 1947 (Registrar) Huntington Williams Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18 1947 at 9:40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1947 to 11-18 1947 and that I last saw him alive on 11-18 1947

Immediate cause of death — Duration
877 1. Cardiac failure
2. Anuria
Due to Hypertensive cardio-vascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent A. Lacaca M. D.
Address Franklin Square Hospital Date signed 18 Nov 47

PLEASE WRITE PLAINLY, with ordinary pen and ink. Do not use pencil. Fill all blanks; if none, write none, or insert "unknown" where the information cannot be obtained. Be sure to answer each question. Define clearly and accurately the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G57097
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 W. Lombard Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT VICTOR

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-16-8778

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma V. Victor

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Sept 10 - 1868

8. AGE: Years	Months	Days	If less than one day
79	2	8	hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation Tailor.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Emma V. Victor
(b) Address 1410 W. Lombard St

17 (a) Burial (b) Date thereof Nov 21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto - Md.

18 (a) Funeral director Thomas J. Kenny Inc.
(b) Address Collins & Fulmer Sts.

NOV 19 1947 (b)
(Date rec'd by registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1947, at 11 a M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Coron. Occlusion Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 11-18-47

correct age is especially important. Physicians: please write the cl

G57098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G57098

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Every question should be answered. Where there is no correct answer, write "None" or "Unknown" as the case may be. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Linwood (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Clarence Ruben Shaver
3 (b) If veteran, name war None
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Myrtle Bratner Shaver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/28/44 1884

8. AGE: Years	Months	Days	If less than one day
63	5	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Enoch Shaver
FATHER 13. Birthplace Maryland
MOTHER 14. Maiden Name Mary Ellen Baker
MOTHER 15. Birthplace Maryland

16 (a) Informant Wife
(b) Address Linwood, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22-47 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location Westminster, Md.

18 (a) Funeral director H. O. Hartsuff & Sons
(b) Mason Bridge & Nan Wenchester

19 (a) NOV 20 1947 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1947 at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7/47 19 to 11/19 1947 and that I last saw h.i.m alive on 11/19 1947

Immediate cause of death Pulmonary embolism — Duration 2 days.
Due to
Due to
Other Conditions Carcinoma of cervix - Stage I
(Include pregnancy within 3 months of death)
Date of operation 11/11/47
Major findings of operation: Carcinoma of cervix - stage I
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Duncan M.D.
Address Union Memorial Hosp. Date signed 11/19/47

VS 150

57099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 57099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5227 Patrick Henry Drive.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT LEROY CANNON

3 (b) If veteran, name war	3 (c) Social Security Account No.
W. W. #2	

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced.~~
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11th 1924

8. AGE: Years	Months	Days	If less than one day
23	10	8	hr. min.

9. Birthplace Savannah Ga.
(Town, county, and state)
10. Usual Occupation Shafter
11. Industry or business Hunt Construction Co.

FATHER
12. Name Eugene L. Cannon
13. Birthplace N.C.

MOTHER
14. Maiden Name Lontine Barrow
15. Birthplace Florida

16 (a) Informant Sarah Cannon
(b) Address 5252 Patrick Henry Drive

17 (a) Burial (b) Date thereof 11/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ U.S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 (a) NOV 20 1947 Huntington for Williams Mortuary
(Date rec'd by registrar)

VS 151

correct age is especially important. Physicians: please

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1947, at 5.40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, traumatic

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-17-47 10 p. M.
(b) Where did injury occur? Bethelem Steel Co. Sparrows Pt. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.
(d) Means of injury Fell from soaking pit

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 11-19-47

657100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

Registered No. 657100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D. A.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 E. 22nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Gunter (Gunter)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1887

8. AGE: Years 60 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation -

11. Industry or business -

FATHER
12. Name Keys
13. Birthplace Baltimore

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore

16 (a) Informant Mrs. Wilson Hann
(b) Address 1609 Bolton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 20 1947 (Date rec'd by Registrar) (b) Huntington Holliaque M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1947, at 7:27 M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 11/19/47

correct age is especially important. Physician: please write this

VS 151

G57101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57101

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina St.
(c) Hospital or institution: St. Joseph's 8.4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 E. Mura St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. McKenna

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-4729

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of ~~husband or~~ wife Gertrude McKenna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/22/1884

8. AGE: Years	Months	Days	If less than one day
63	5	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Boiler Maker
11. Industry or business Beth. Steel

FATHER
12. Name McKenna
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mary E Steinsdoerfer
(b) Address 2112 E Mura St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) NOV 20 1947 (Date rec'd by registrar) (b) Huntington Williams

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MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 1947 to 11/19 1947, and that I last saw him alive on 11/19 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May M.D.
Address 1400 N. Caroline St. Date signed 11/19/47

X

G57102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57102

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4038 Park Heights Ave
(c) Hospital or institution: 15-13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4038 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Drohan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife: John C. Drohan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 5/5/1866

8. AGE: Years	Months	Days	If less than one day
81	6	12	hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: Robert Conway
13. Birthplace: Unk.

MOTHER
14. Maiden Name: Regina McNevin
15. Birthplace: Unk.

16 (a) Informant: C. V. Lemmon
(b) Address: 4611 Pk. Hgts.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/20/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Baltimore City,

18 (a) Funeral director: C. Vernon Lemmon
(b) Address: 4611 Park Heights Ave.

NOV 20 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1947, at 8:30 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: William F. Helfrich M.D. Medical Examiner.
Date signed Nov 17, 1947

correct age is especially important. Physicians: please write the

57103 B.C.H. 4-9307 BALTIMORE CITY HEALTH DEPARTMENT / 160c X Registered No. 657103

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 Fayette Street
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) ____
(e) Length of stay in Baltimore (yrs., mos., or days) ____

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Edgewater Apartments (If rural give location)
(e) Citizen of foreign country? ____ (Yes or No) If yes, name country ____

3 (a) FULL NAME Baby Dempsey

3 (b) If veteran, name war ____
3 (c) Social Security Account No. ____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife – 6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 2/25/47

8. AGE: Years	Months	Days	If less than one day
			____ hr. 15 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation –
11. Industry or business –

FATHER
12. Name James Dempsey
13. Birthplace Tulsa, Oklahoma

MOTHER
14. Maiden Name Eleanor Chapman
15. Birthplace Wheeling, West Virginia

16 (a) Informant: Hospital Records
(b) Address 2024 Fayette Street

17 (a) – (Burial, cremation, or removal) (b) Date thereof Feb. 25, 1947 (month) (day) (year)
(c) Cemetery or crematory ____
Location Johns Hopkins Medical School

18 (a) Funeral director –
(b) [redacted] Huntington Williams, M.D. Registrar
19 MAR 20 1947 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1947 at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1947 to Feb 25 1947 and that I last saw h.i. alive on Feb 25 1947

Immediate cause of death	Duration
Intrauterine asphyxia	2 hrs.
Cause unknown	
Due to Probably accord cord prolapse.	
Due to Cerebral anoxia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation ____
Major findings of operation: ____
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature D. M. Dixon M. D.
Address ____ Date signed ____

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

G57104 B of H 4.9436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. G57104

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPHS HOSP. 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 E. FEDERAL ST.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** PAULERO, Catherine Burns (Catherine B. Paulero)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11/17/47

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace BALTO, MD
(Town, county, and state)

10. Usual Occupation INFANT

11. Industry or business

FATHER
12. Name Ralph Paulero
13. Birthplace Virginia

MOTHER
14. Maiden Name Evelyn Burns
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Catherine Burns
(b) Address 1202 E. Federal Street

17 (a) Burial (b) Date thereof 11/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Ave

19 (a) NOV 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on 11/19 1947

Immediate cause of death: RESPIRATORY FAILURE — Duration:
Due to: TRACHEO-ESOPHAGEAL FISTULA, & ATRESIA
Due to: OF ESOPHAGUS
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 11/19/47
Major findings of operation: ATRESIA OF ESOPHAGUS
of autopsy: TRACHEO-ESOPHAGEAL FISTULA

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry R Porter M. D.
Address H. Joseph's Hosp. Date signed 11/19/47

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Do not fold. Do not write above or below the lines. Be sure to write the causes of death clearly and legibly. Give correct age. Do not abbreviate. Write out the full name and do not use initials. If the deceased was a married woman, write her own given name, not that of her husband. Do not use words "do," "same," or ditto marks. Be sure to answer every question. If there is no entry to be made, write "None" or "Unknown" as the case may be. Physicians: please write correct age is especially important.

G57105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G57105

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1913 Eutaw Place
(b) Street address 700 Fleet St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7201 Echodale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT MORY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of husband or wife Sarah F. Mory
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1855

8. AGE: Years	Months	Days	If less than one day
92	9	0	hr. min.

9. Birthplace Lineport, Pa.
(Town, county, and state)
10. Usual Occupation Retired Paperhanger
11. Industry or business

FATHER
12. Name Abner Mory
13. Birthplace Pa.

MOTHER
14. Maiden Name Ellamina Kemmerer
15. Birthplace Pa.

16 (a) Informant Mrs. John J. Winter
(b) Address 3201 Echodale Ave.

17 (a) Burial (b) Date thereof 11/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) NOV 20 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

correct age is especially important. Physicians: please write clearly.

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MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 19 47 at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumania
Marked coronary arteriosclerosis
Arteriosclerotic cardio-vascular-renal disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Morrell M.D.
Medical Examiner.
Date signed 11/20/47

G57106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G57106 Registered No.

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3904 Bateman Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Bateman Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAMSON WADE MOSS

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Hattie Hutchison Moss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1877

8. AGE: Years 70 | Months 0 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chief Clerk
11. Industry or business B. & O. R. R.

FATHER
12. Name Charles David Moss
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Louisa Frazier
15. Birthplace Balto., Md.

16 (a) Informant Mrs. James H. Moss
(b) Address 19 Woodlawn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Balto. MD

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 20 1947 (Date filed by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1947 to 11-18 1947, and that I last saw h[illegible] alive on 11-16 1947

Immediate cause of death: Coronary Thrombosis — Duration: 4 da.
Due to: Arteriosclerosis — 9 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hubert A Blake
Address Med. Arts. Bldg. Date signed 11-19-47

V S 150

G57107 S.C.# 3-91[illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G57107

PLEASE WRITE PLAINLY, WITH INK. Use no abbreviations. Describe the causes of death clearly and legibly. Give full name of hospital or institution, and do not report "Home" or "Residence". Give full residence address. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Flowers

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 9, 1947

8. AGE: Years	Months	Days	If less than one day
			17 hr. min.

9. Birthplace Md, Balto.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name C. Flowers.
13. Birthplace Summerville S.C.

MOTHER
14. Maiden Name Mary Lou Dingle
15. Birthplace Summerton S.C.

16 (a) Informant Mary Lou Flowers
(b) Address 1500 Myrtle Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 NOV 20 1947 (Date Rec'd by Registrar) (By) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1947, at 2:59 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1947 to Nov 10 1947, and that I last saw her alive on Nov 10 1947.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Intrauterine hemorrhage	
Due to Prolonged labor.	
Other Conditions Prenatal atelectasis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos Klein
Address Univ Hosp Date signed 11/20/47

University Medical School NOV 1947
Commissioner of Health

VS 180

57108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46M

G57108 Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Church Creek (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Emerson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Wyoming (Town, county, and state)

10. Usual Occupation Iron Worker

11. Industry or business

FATHER
12. Name Sam
13. Birthplace Wyoming

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Charles Emerson
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 1 1947 Commissioner of Health

18 (a) Funeral director
(b) Address

19 NOV 20 1947 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1947, at 6.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1947 to 11-13 1947, and that I last saw him alive on 11-13 1947.

Immediate cause of death Anoxia + Cardiac failure

Due to CA of retro-peritoneal space, ? primary ? Small intestine

Due to multiple metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Exploratory 2-19-25-47

Major findings of operation: Same as above

of autopsy: not obtained

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Jamison M. D.
Address ~~Univ~~ University Hosp Balto. Date signed 11-13-47

X

G57109 B.C.* 5-94266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G57109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Everyone is required by law to report the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St.
(c) Hospital or institution: Hosp. for the Women of Md. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 32 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr. 32 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore - 15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3738 Dolfield Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Peterson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1947

8. AGE: Years	Months	Days	If less than one day
			1 hr. 32 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Morris Peterson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Myra Wilma Paty
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Morris Peterson
(b) Address 3738 Dolfield ave, Balto.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory University Medical School NOV , 1947
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) NOV 20 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1947, at 11½ A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15, 1947 to Nov. 15 1947 and that I last saw h.s.s. alive on Nov. 15 1947.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. G. Spencer Jr. M. D.
Address Hosp. for the Women of Md. Date signed 11-15-47

VS 150

657110 BALTIMORE CITY HEALTH DEPARTMENT 657110
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24-4
(c) Hospital or institution: South Baltimore General Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. B & O Y.M.C.A. 1800 Webster St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM DUTROW

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Hattie Dutrow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10 1892

8. AGE: Years 55 | Months 1 | Days 7 | If less than one day: hr. min.

9. Birthplace Boyds Md (Town, county, and state)

10. Usual Occupation R.R. Foreman

11. Industry or business R.R.

FATHER 12. Name Jake Dutrow
13. Birthplace Md.

MOTHER 14. Maiden Name Ella Marshall
15. Birthplace Md.

16 (a) Informant Hattie Dutrow
(b) Address 4738 Carlingford Rd. Washington D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22- (month) (day) (year)
(c) Cemetery or crematory Boyds Cemetery
Location Boyds Md.

18 (a) Funeral director Enoch L. Gaither
(b) Address Gaithersburg Md.

19 NOV 20 1947 (Date rec'd by Registrar) (b) Entering for Wilmer Miller Registrar

correct age is especially important. Punctuate. Paragraph.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17, 1947, at 10.05 P.M.

21. I certify that I took charge of the remains described above, held an insp. & ing. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 11-18-47

VS 151

57111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 057111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 The Alameda (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest William Todd

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lillie Todd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/17/1858

8. AGE: Years	Months	Days	If less than one day
89	1	1	hr. min.

9. Birthplace Toronto, Canada (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B. & O. R. R.

FATHER
12. Name Alphens Todd
13. Birthplace London, England

MOTHER
14. Maiden Name Sarah St. John
15. Birthplace London, England

16 (a) Informant Mrs. Lillie Todd
(b) Address 2910 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians; please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1947, at 2:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1947 to Nov 18 1947 and that I last saw h[illegible] alive on Nov. 18 1947.

Immediate cause of death Bronchopneumonia
(a) failure

Due to Contusion of right lung

Due to

Other Conditions Fractured neck of right femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Nov. 11 6:45 P.M.
(c) Where did injury occur? 2910 The Alameda (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell & injury to head.

23. Signature Hospital Howard J. Madden, M.D.
Address The Union Memorial Date signed 11/18/47 M. D.

VS 150

Dr King 1210 Eutaw Place Ma 1387

G57112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registration No. G57112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 St. Paul St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 St. Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louise McGhie McLane

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or~~ divorced: Married

6 (b) Name of husband Allen F. McLane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12th 1894

8. AGE: Years 52 | Months 11 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Duluth Minn.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name James D. McGhie
13. Birthplace Scotland

MOTHER
14. Maiden Name Carolina (Unknown)
15. Birthplace Scotland

16 (a) Informant Allen F. McLane
(b) Address 1001 St. Paul St. H-10

17 (a) Cremation (b) Date thereof 11/20/47
(~~Burial~~, cremation, ~~or removal~~) (month) (day) (year)
(c) ~~Cemetery~~ or crematory Greenmount
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 20 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19th 1947, appar. at 4.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9 1947, to Oct. 24 1947, and that I last saw h-er alive on Oct. 23 1947.

Immediate cause of death (Pulmonary embolism. | Duration

Due to Phlebothrombosis, R. leg. |

Due to Previous trauma. |

Other Conditions Hypertension. Polycythaemia. mild. |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Previous accident.
(b) Date of occurrence Early Sept. 47. at M
(c) Where did injury occur? Addison, Maryland
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fall down steps

23. Signature John D. King M. D.
Address 1210 Eutaw Pl. Date signed Nov. 20 47

Howard J. Mullen, M.D. X
(Add.)

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G57113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G57113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 Poplar Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Regulski

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-0958

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 1895

8. AGE: Years	Months	Days	If less than one day
52 51	8	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Operator on Derrick
11. Industry or business Arundel Corp.

FATHER
12. Name Frank Regulski
13. Birthplace Poland

MOTHER
14. Maiden Name Antonette ?
15. Birthplace Poland

16 (a) Informant Mrs. Mary Regulski
(b) Address 332 Poplar Ave. Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-47 (month) (day) (year)
(c) Cemetery St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 706 S. Ann st

19 (a) NOV 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

Correct age is supremely important. Physician, please

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1947 at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to 896 his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions HURRY Mural Thrombosis Myocardial Aneurysm left ventricle
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. (Medical Examiner)
Date signed 11-19-47

VS 151

G57114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No. G57114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 59 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 S. Bond St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Vincent Borowiak

3 (b) If veteran, name war: WW 2

3 (c) Social Security Account No. 212-16-0241

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1923

8. AGE: Years	Months	Days	If less than one day
24	1	0	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B & O Railroad

FATHER
12. Name Mr. Borowiak
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Miesowolowska
15. Birthplace Poland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A. Weber
(b) Address 705 S Chin st

19 (a) NOV 20 1947 (Date rec'd by registrar) (b) Huntington Hilliard, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1947, at 3:35P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1947, to Nov. 18 1947, and that I last saw him alive on Nov. 18 1947.

Immediate cause of death	Duration
Emiza. Tumor of Posterior Chest	
Due to	
Due to	
Other Conditions Bronchial pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Grabstald, M.D. M. D.
Address U. S. Marine Hosp. Date signed 11-18-47

V S 190

PLEASE WRITE CLEARLY and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99

G57115 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town ~~Baltimore~~ Fort Smallwood Rd. Pasadena P.O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter W. Lee

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-20-6838

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1894

8. AGE: Years	Months	Days	If less than one day
63	1	24	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Box-maker
11. Industry or business

FATHER
12. Name Samuel Lee
13. Birthplace Virginia.

MOTHER
14. Maiden Name Lucy Lee
15. Birthplace Virginia

16 (a) Informant Lawrence Lee
(b) Address Ft. Smallwood Rd. Pasadena P.O.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 22 47 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST. -30

19 (a) NOV 20 1947 (To be filled in by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1947, at 2:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1947, to 11-19 1947, and that I last saw him alive on 11-19 1947.

Immediate cause of death: Pulmonary embolism due to coronary atherosclerosis. — Duration: few min.

Due to:

Due to:

Other Conditions Buergers disease 4 weeks.
Left lumbar sympathectomy.
(Include pregnancy within 3 months of death)
Date of operation 11-17-47
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Johnson M. D.
Address Mercy Hospital Date signed 11/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Write the causes of death clearly and legibly. Give correct age in especially important. Physicians: please write this

VS 150

G57116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G57116

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 Rutland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Richard Marshall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Widow

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1908

8. AGE: Years	Months	Days	If less than one day
39	5	15	hr. min.

9. Birthplace Wadesboro N. Carolina
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Julian Marshall
13. Birthplace N. C.

MOTHER
14. Maiden Name Polly Bennett
15. Birthplace N. C.

16 (a) Informant Lillian Marshall
(b) Address 928 Rutland Ave.

17 (a) Burial (b) Date thereof Nov 22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location G. C. County Md.

18 (a) Funeral director Mrs Tott & Ellis & Dyer
(b) Address 1299 N. Carolina

19 NOV 20 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-1947 to 11-18-1947 and that I last saw h~~e~~ alive on 11-18-1947.

Immediate cause of death: Bronchopneumonia and Pericarditis — Duration: 14 days.
Due to: Arteriosclerosis & Hypertension — Duration: 30 days
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. R. Blake M. D.
Address 1327 N. Central Ave. Date signed 11-19-47

VS 150

LW 115285 G57117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G57117 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Waters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21- 1886

8. AGE: Years 61 ? | Months - | Days 29 | If less than one day ____hr. ____min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Wm H. Waters
13. Birthplace Md

MOTHER
14. Maiden Name Mary C. Fettling
15. Birthplace Md

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wes. H. Nelson
(b) Address 1363 Pressman St

19 (a) ____ (b) ____
(Date received by Registrar) Registrar

NOV 20 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19-47 19____, at 12:30 M A

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1947 to Nov, 19 1947, and that I last saw him alive on Nov, 19 19 47

Immediate cause of death Pneumonia — Duration 1 wk

Due to Arteriolar Nephrosclerosis — Duration 1 yr

Due to ____ — Duration ____

Other Conditions Lobar Pneumonia — Duration 1 wk

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Robinson M. D.

Address Balt. City Hosp. Date signed 11/19/47

121a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G57118 Registered No.

write the causes of death clearly and correctly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 E. North Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 E. North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN SOMMER

3 (b) If veteran, name war: SPANISH AMER.
3 (c) Social Security Account No. 215-09-9231-A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Anna (Grimm) Sommer
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March 25, 1882

8. AGE: Years	Months	Days	If less than one day
65	7	25	....hr. ....min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerk - ret. 6 yrs.
11. Industry or business

FATHER
12. Name Charles E. Sommer
13. Birthplace Penna.

MOTHER
14. Maiden Name Rebecca J. Hall
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. John Sommer - Widow
(b) Address 1913 E. North Avenue - 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 NOV 20 1947 (Date rec'd by registrar) (b) Transcription from Milligan Mss

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 19 1947, at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1947, to Nov. 19 1947, and that I last saw h[illegible] alive on Nov. 19 1947.

Immediate cause of death: Apoplexy — Duration 4 days
Due to: Hypertension and Arteriosclerosis — 6 yrs. / 6 yrs.
Due to: — (2)
Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature David Schneider M. D.
Address 1101 N. Milton Ave Date signed 11-19-47

VS 150

839

57119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 444 S. Bentalou St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 444 S. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonio DiLeonardi

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Josephine Frazitta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) I/I7/I88I

8. AGE: Years	Months	Days	If less than one day
66	IO	I	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Cooper
11. Industry or business Kimbell & Tyler Co.

FATHER
12. Name Albert DiLeonardi
13. Birthplace Italy

MOTHER
14. Maiden Name Bridget Pipitone
15. Birthplace Italy

16 (a) Informant Family
(b) Address 444 S. Bentalou St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof II/2I/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Edmondson Ave.

18 (a) Funeral director James L. McCauley
(b) Address 1307 E. Fort Ave.

19 (a) NOV 20 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1947 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Nov. 1947 and that I last saw h[illegible] alive on Nov 14 1947

Immediate cause of death Arteriosclerotic cardio-vascular disease — Duration 3 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert DiLeonardi M.D.
Address 2030 Wilkens Date signed Nov 19 47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

Registered No. G57120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2709 Tivoly
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Tivoly
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN LORETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Sophia Lorett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10, 1865

8. AGE: Years	Months	Days	If less than one day
82	9	9	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Physical Instructor

FATHER
12. Name Philipp Lorett
13. Birthplace Germany

MOTHER
14. Maiden Name Katherina Kniessel
15. Birthplace Germany

16 (a) Informant Written Statement John Lorett
(b) Address 2709 Tivoly Ave

17 (a) Burial (b) Date thereof Nov 22 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Wm. Mrs. John W Geufel's Son
(b) Address 5311 Edmondson Ave

19 (a) NOV 20 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19/47 19 8:10 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Beers M.D.
Medical Examiner.
Date signed 11/19/47

X

57121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered 57121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) 56 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 W. LANVALE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HENRIETTA FRANCIS HIDEY

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife CARVILLE E. HIDEY

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MAR 25, 1891

8. AGE: Years 56 | Months 7 | Days 23 | If less than one day 24 hr. ____ min.

9. Birthplace BALTIMORE — MARYLAND
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business NONE

FATHER
12. Name BERNHARDT WICH
13. Birthplace GERMANY

MOTHER
14. Maiden Name ROSINA SCHNEIDER
15. Birthplace BALTIMORE, MD

16 (a) Informant MRS. O.B. COBLENTZ, JR.
(b) Address COTONSVILLE, MD

17 (a) Burial (b) Date thereof Nov. 21. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mrs. Jno. F. Teufel & Son
(b) Address 5311 Edmondson Ave

19 (a) NOV 20 1947 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 NOVEMBER 1947, at 11 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Nov. 1947, to 18 Nov 1947, and that I last saw HER alive on 18 Nov. 1947

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	
Due to CEREBRAL HEMORRHAGE	5 DAYS
Due to HYPERTENSIVE CARDIOVASCULAR DISEASE	+ 10 YRS
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph B Aigner, Jr M.D.
Address Woman's Hosp. Date signed 11/18/47

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Do not abbreviate. Write the causes of death clearly and legibly. Give full name of deceased. Do not use initials alone. If residence is in city, give street address. If in country, give post office. Fill in all items. Be sure that the information given is correct and complete. Write in the date of death. Do not omit the hour of death. Write the age in years, months, and days. If less than one day, write the hours or minutes. Write the causes of death clearly and legibly. Physicians: please write the cause to which death should be charged statistically. Be sure that the cause of death is correctly stated. Be sure that the age is especially important. Physicians: please write

VS 130

X

G57122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 832

Registered No. G57122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 Compton St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Compton St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Frank E. Walton

3 (b) If veteran, name war	3 (c) Social Security Account No. 218-10-3798
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ella Walton (nee Anderson) 6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) January 5, 1870

8. AGE: Years	Months	Days	If less than one day
77	10	13	...hr. ...min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Joseph Walton
13. Birthplace Balto Md.

MOTHER 14. Maiden Name Elizabeth ?
15. Birthplace Balto Md.

16 (a) Informant Mrs. Ella Walton (Wife)
(b) Address 904 Compton St. Balto 30 Md

17 (a) Burial (b) Date thereof (month) Nov. (day) 20 (year) 1947
(burial, cremation, or removal)
(c) Cemetery or crematory Glen Haven Mem.
Location Anne Arundel County Md.

18 (a) Funeral director C. Howard Evans
(b) Address 4007 St. Charles St City 30

19 (a) NOV 20 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June, Nov. 18 1947, at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Nov 18 1947 and that I last saw h.e alive on Nov 18 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Cerebral Hypertension	1 yr
Due to Arterio Sclerosis	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. B. Mello M.D.
Address 1279 Hillsmere Date signed 11/19/47

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Be sure that the information given is correct and complete. Personal data furnished by informant. Medical certification by physician. Accuracy of age is especially important.

VS 180

57123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57123 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ashburton Nursing Home
(c) Hospital or institution:
Home 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ashburton Nursing Home
666 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose M. Kennedy

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George L.a
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February-21-1874

8. AGE: Years	Months	Days	If less than one day
73	8	28	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name James W. Clay
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma R. Britton
15. Birthplace Virginia

16 (a) Informant George L. Kennedy
(b) Address 666 W. Fayette St.

17 (a) Burial (b) Date thereof Nov. 21
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street, Baltimore

19 (a) NOV 20 1947 (Huntington Williams, M.D.
(Date rec'd by registrar)

correct age is especially important. Physicians: please write

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Nov 19 1947 and that I last saw her alive on Nov 19 1947.

Immediate cause of death	Duration
Acute Cardiac Dilitation	3 days
Due to Cardio vascular disease	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Klassman M. D.
Address 753 N Fulton Ave Date signed Nov 19 1947

G57124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 830a

G57124 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 Huntingdon Ave
(c) Hospital or institution:
12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Meride R E. Tiller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of husband Stanley C. Tiller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4th 1904

8. AGE: Years 43 | Months 4 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Stanley C. Tiller
(b) Address 2107 Huntingdon Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/22/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 NOV 20 1947 (Date received by Registrar) (b) Registrar

VS 150

correct age is especially important. Physicians: please w

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1, 1947 to Nov. 19, 1947 and that I last saw h e alive on Nov. 16, 1947.

Immediate cause of death Cerebral apoplexy — Duration
Due to Hypertension / Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Not

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Silvia L. Frey M.D.
Address 23 W Eutaw Place Date signed 11/20/47

657125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12-1a

657125 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Pearson

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1861

8. AGE: Years	Months	Days	If less than one day
86	7	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Oliver Pearson
(b) Address 2119 McHenry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 21-47 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Holy Cross

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 20 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

correct age is especially important. Physicians: please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1947, to Nov 16 1947 and that I last saw h[illegible] alive on Nov 16 1947

Immediate cause of death Cerebral Hemorrhage Duration
Due to Abdominal Ascites
Due to Cancer of Intestines

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theo Koeneman M.D.
Address 715 N Broadway Date signed 11/20/47

VS 150

X

57126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 95B

Registered No. 57126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Kennedy Ave # 18
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Hevey

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-03-9830

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife: Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1907

8. AGE: Years	Months	Days	If less than one day
40	8	14	hr. min.

9. Birthplace Baltimore, Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business

FATHER
12. Name James J. Hevey
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah E. Sweeney
15. Birthplace Ireland

16 (a) Informant Mrs. Joseph J. Hevey
(b) Address 4716 Rhinelick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22/47 (month) (day) (year)
(c) Cemetery or crematory Our Calvert Cal. Gdns.
Location 4300 Old Frederick Rd

18 (a) Funeral director Edmund W. Corkran Sons
(b) Address 924 Mayer St.

19 (a) NOV 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1947, at 9:25 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1947 to Nov 19 1947, and that I last saw him alive on Nov. 19 1947

Immediate cause of death	Duration
Cardiac failure	
Due to Marked Cardiac Decompensation	
Due to Rheumatic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Burkhart, M.D.
Address Md. Gen'l Hospital Date signed 11/19/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓48B

Registered No. 057127

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 W. Lanvale St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Nannie Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	married

6 (b) Name of husband or wife James Williams
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) august 15, 1898

8. AGE: Years	Months	Days	If less than one day
49	3	3	— hr. — min.

9. Birthplace Henderson, N. C. (Town, county, state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Sam Small
13. Birthplace Henderson, N.C.

MOTHER
14. Maiden Name Mary Williams
15. Birthplace Henderson, N.C.

16 (a) Informant Mrs. Catherine Richbell
(b) Address 1313 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/47 (month) (day) (year)
(c) Cemetery or crematory
Location Suffolk Va

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bartley Ave

19 (a) NOV 20 1947 (Date received by registrar) (b) Signature for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11.18.47 19 , 3P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6.19.46 19 to 11.18.47 19 , and that I last saw h[illegible] alive on 11.18.47 19 .

Immediate cause of death	Duration
Carcinomatosis	aug. 1947
Due to Carcinoma uteris	June 1946
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. Fair M. D.
Address 400 N. Carrollton Ave Date signed 11.18.47

VS 1

57128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G57128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eutaw Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Shady North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Albert Grant Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/11/1857

8. AGE: Years 89 | Months 11 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Milton
13. Birthplace West Virginia

MOTHER
14. Maiden Name Mary Ford
15. Birthplace West Virginia

16 (a) Informant St. Agnes Hospital
(b) Address Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Baltimore Fayette St.

19 (a) NOV 20 1947 (Local registrar) (b) Huntington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1947, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1947 to 11/19 1947 and that I last saw h.. alive on 11/19 1947.

Immediate cause of death	Duration
Cerebral hemorrhage.	
Due to Arteriosclerotic heart disease.	
Due to	
Other Conditions Cachexia due to metastasis from Ca Prostate	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh Wells M. D.
Address 1316 Eutaw Pl. Date signed 11/21/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G57129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

G57129 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard E. Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Violet A. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1912

8. AGE: Years	Months	Days	If less than one day
35	6	14	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jahue Thompson
13. Birthplace W. Va.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Violet A. Thompson
(b) Address 119 S. Broadway

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-20-47 (month) (day) (year)
(c) Cemetery or crematory Sunset Cemetery
Location Clarksburg, W. Va.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

NOV 20 1947 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19/47, 19..., at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to

Other Conditions Laceration Mouth

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/19/47 1:00 P.M.
(b) Where did injury occur? Home (119 S. Broadway)
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self Inflicted - Illuminating gas

23. Signature John R. Weaver M.D. Medical Examiner
Date signed 11/20/47

gas burner stove - inhaled

57130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 57130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BALTIMORE CITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~3600~~ 3605 Pulaski Highway
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY J DASCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Doris A. (nee Hill)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1914

8. AGE: Years 33 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Welsch Co

FATHER
12. Name Harry Dasch, Sr
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Lillian Vogel
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Doris Hill Dasch
(b) Address 3605 Pulaski Highway

17 (a) Burial (b) Date thereof 11, 21, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd., Balto. Md

18 (a) Funeral director Charles E Schimunek
(b) Address 2601 E. Madison Street

19 (a) NOV 21 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17, 1947, at 8.37 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, traumatic.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 26/4

(a) Date of injury 11-16-47 9 P. M.
(b) Where did injury occur? Pulaski Highway & Conkling Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian- Struck by auto

23. Signature [signature] M.D.
Medical Examiner
Date signed 11-18-47

VS 181

C57131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. C57131

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2620 Hollinsferry Rd.
(c) Hospital or institution: 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2620 Hollinsferry Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sandra Hargue

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/14/47

8. AGE: Years | Months | Days | If less than one day 1 hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Hargue
13. Birthplace Dillard, S.C.

MOTHER 14. Maiden Name Almeda Crosland
15. Birthplace Dillard, S.C.

16 (a) Informant Mother (Almeda Crosland)
(b) Address 2620 Hollinsferry Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory University Medical School NOV 1947
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1947 at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1947 to Nov. 10 1947, and that I last saw her alive on Nov. 10 1947.

Immediate cause of death	Duration
Premature Birth	
Due to Spontaneous Abortion (at about 5-6 th. month).	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. W. Anderson M. D.
Address 1612 Edmondson Ave. Date signed 11-10-47

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G57132 B.C.# 4-13808 BALTIMORE CITY HEALTH DEPARTMENT G57132

CERTIFICATE OF DEATH 161a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1442 Treatman (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charline Rochelle Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/2/47

8. AGE: Years | Months | Days | If less than one day 9 hr. 15 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory University Medical School NOV 1 1947

Location

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12/47 19..., at 6:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis Neonatorum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.

Date signed 11/12/47

57133 BC 4-95380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G57133 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5022 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Philpott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/7/47

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory University Medical School NOV 1 1947

Location

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1947, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Atelectasis

Prematurity

Due to

Other Conditions Bruises of left shoulder and hip. Patent foramen ovale

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 11-10-47

G57134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 170 c

Registered No. G57134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N. Washington Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mark O. Bukin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a)..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery University Medical School NOV 1947
Location.....

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (a) NOV 21 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

Do not write in this space. Copy is for information only.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1947 at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & intracranial Hemorrhage

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-7-47 at 5:30 P.M. Balto. Co.
(b) Where did injury occur? Pulaski Highway & Rossdale Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Ped. struck by truck

23. Signature Earl R. Krug M.D. Medical Examiner.
Date signed 11-8-47

X

G57135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G57135

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 23-1
(b) Street address
(c) Hospital or institution: South Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 St. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur L. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
University Medical School NOV 1947
(c) Cemetery or crematory
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 21 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1947, at 6 55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Tuberculous pneumonia

Due to Cirrhosis of liver.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 11-10-47

57136 Letzer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 057136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Fremont 9-6
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5D.
(e) Length of stay in Baltimore (yrs., mos., or days) 76 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2755 Fenwick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert A. Letzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 27, 1871

8. AGE: Years	Months	Days	If less than one day
76	7	23	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Albert A. Letzer
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Meester
15. Birthplace Dorchester

16 (a) Informant Howard A Sweeten
(b) Address 3301 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22- (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Bloom St

19 NOV 21 1947 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1947, at 1285 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1947, to 11/19 1947, and that I last saw h. alive on 11/19 1947.

Immediate cause of death	Duration
Cachexia following intestinal obstruction	
Due to following Carcinoma of sigmoid	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/13/47

Major findings of operation: Metastasis (Cecotomy only)

of autopsy: " CA Sigmoid

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Mitchell M.D.
Address Bal. Gen. Hosp. Date signed 11/19/47

correct age is especially important. Physicians: please write the

VS 150

57137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. 657137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution: Pine Ridge Nursing Home 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Sheffield Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: THOMAS E. STEWART

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nettie Virginia Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1865

8. AGE: Years 82 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Lakes District, Md. (Town, county, and state)

10. Usual Occupation Retired Motorman

11. Industry or business Balto. Transit Co.

FATHER
12. Name Alfred Stewart
13. Birthplace Dorchester Co., Md.

MOTHER
14. Maiden Name Frances ?
15. Birthplace Dorchester Co., Md.

16 (a) Informant Mrs. Nettie V. Stewart wife
(b) Address 1516 Sheffield Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 21 1947 (Local registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1947, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1947 to Nov. 17 1947, and that I last saw h. alive on Nov. 17 1947.

Immediate cause of death: Myocarditis
arteriosclerosis
and diabetes mellitus — Duration

Due to

Due to

Other Conditions: Acute cardiac dilatation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Kaden M. D.
Address 2306 Eutaw Pl. Date signed 11-20-47

Please write the correct age is especially important. Physicians:

V S 150

G57138 SURGERY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

Registered No. G57138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted] N. Broadway
(c) Hospital or institution:
CHURCH HOME AND HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Carroll
(c) City or town BALTIMORE, [redacted] — MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. WOOD BINE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah M. Mary Mrs.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	(Married)

6 (b) Name of husband or wife MR. WALTER SINGLETON
SON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23 1867

8. AGE: Years	Months	Days	If less than one day
70	9	28	hr. min.

9. Birthplace [redacted] Maryland
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business —

FATHER
12. Name Kappler / John
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Louise [redacted] Burkley
15. Birthplace Maryland

16 (a) Informant Son
(b) Address 3835 Yolanda Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/47 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN CEMT
Location BALTO; MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO. MD

19 (Date rec'd by registrar) NOV 21 1947 Huntington for Williams, M Registrar

Correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1947, at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Nov 19 1947, and that I last saw h.c.r. alive on Nov 20 1947.

Immediate cause of death Cardiac Insufficiency
Arteriosclerosis Hemorrhage Duration
Arteriosclerosis, Generalized
Due to
Due to
Other Conditions Obstruction & Carcinoma Bile Duct
Partial intestinal obstruction
(Include pregnancy within 3 months of death)
Date of operation Oct 13 1947
Major findings of operation: Chronic Obstruction
Rupture and adhesions to abdominal wall
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph D'Antonio
Address Church Home & Hosp. Date signed 11/20/47 M.D.

VS 150

7139 BALTIMORE CITY HEALTH DEPARTMENT G57139

CERTIFICATE OF DEATH ✓ 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp. 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ Days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1943 N. Woodstock St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olympia Tracy Conway

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Joseph A. Conway | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1892

8. AGE: Years 55 | Months 6 | Days — | If less than one day hr. min.

9. Birthplace Bayou La Fusee, La. (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Joseph Falgout
13. Birthplace Virginiana

MOTHER 14. Maiden Name Evelyn Bell
15. Birthplace France

16 (a) Informant Evelyn M. Banks
(b) Address 911 E. Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Geo. Leroy A. Hellen
(b) Address 1631 Druid Hill Ave

19 NOV 21 1947 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1947, at 4:21 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/7 1946 to 11/19 1947
and that I last saw her alive on 11/19 1947

Immediate cause of death	Duration
Cardio-Vascular-Renal Disease	2 yrs
Due to Chronic Hypertension	2 yrs.
Due to Mitral Insufficiency	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Louise Young M. D.
Address 1100 Druid Hill Ave Date signed 11/19/47

correct age is especially important. Physicians: please write the

VS 150

1310

57140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 57140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 N. Washington St.
(c) Hospital or institution: 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Ahern

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1867

8. AGE: Years	Months	Days	If less than one day
80	5	30	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Frederick Kiessling
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emily Holt
15. Birthplace Md.

16 (a) Informant James Ahern
(b) Address 2007 N. Washington St.

17 (a) Burial (b) Date thereof 11/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) NOV 23 1947 (b) Thurlington Williams, M.D.
(Date received) (Registrar)

VS 150

correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-20 1947, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2- 1947, to Nov 20 1947, and that I last saw her alive on Nov 20- 1947

Immediate cause of death: Coronary Thrombosis — Duration: 1 day
Due to: Chronic Myocarditis — 5 yrs
Due to:
Other Conditions: Arterio-Sclerosis — 8 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall
Address 1631 E. North Ave Date signed M. D. 11/20/47

X

G57141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G57141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Division St
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Division St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Meares

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 57 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation maid

11. Industry or business

FATHER — 12. Name Richard Hall
13. Birthplace Md.

MOTHER — 14. Maiden Name Mary Hawkins
15. Birthplace Md.

16 (a) Informant Edward Hall
(b) Address 1609 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.,

19 NOV 21 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1947 at 11 25 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-Nov 1947 to 20-Nov 1947 and that I last saw h[illegible] alive on 11-20 1947

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to: Arteriosclerosis — 1 yr
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature N. Atwell Jones M. D.
Address 5354 Dorchester Date signed 11-21-47

correct age is especially important. If uncertain, please write "about"

VS 150

X

357142

AB-115219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V66B

G57142 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 May Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Bantum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?

8. AGE: Years	Months	Days	If less than one day
49?			hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Junk

11. Industry or business

FATHER
12. Name William Bantum (D
13. Birthplace N.Y.

MOTHER
14. Maiden Name Kate ?
15. Birthplace New York

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11-20-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) NOV 21 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17- 1947, at 6.15 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14- 1947 to 11-17- 1947 and that I last saw h im alive on 11-17- 1947

Immediate cause of death	Duration
Pulmonary Edema	day
Due to Malnutrition	
Due to	
Other Conditions Hypostatic pneumonia bilateral	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Robinson Jr M. D.
Address Balt. City Hosp. Date signed 11/19/47

correct age, is especially important. Physicians, please write plainly.

V S 150

111 C

57143 LW 115223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 657143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mintree Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20- 1897

8. AGE: Years 50 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mintree Walker
13. Birthplace Va.

MOTHER
14. Maiden Name Lottie ?
15. Birthplace Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Catonsville Md.

18 (a) Funeral director G. Holstead
(b) Address 98 Druid Hill Ave.

19 NOV 21 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

V S 150

correct age is especially important. Physicians: please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 19 47, at 8:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 19 47 to Nov. 17 19 47, and that I last saw h im alive on Nov. 17 19 47

Immediate cause of death

Uremia — Duration 2-3 days

Due to Acute Myelogenous Leukemia — Duration 1-2 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. P. Sanderson M. D.
Address Balto City Hosp. Date signed 11-18-47

7144 LW 114893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C57144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Johannesen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Doris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25- 1885

8. AGE: Years 61 | Months 10 | Days 25 | If less than one day ....hr. ....min.

9. Birthplace N.C. (Town, county and state)

10. Usual Occupation Laborer (Unemployed)

11. Industry or business

FATHER
12. Name ? Unknown
13. Birthplace ? Unknown

MOTHER
14. Maiden Name ? Lon —
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22 1947 (month) (day), (year)

(c) Cemetery or crematory Mt Calvary
Location Joseph L. Gross

18 (a) Funeral director Robert L. Gross
(b) Address 1216 W. Caroline St

19 NOV 21 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19- 1947, at 9:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31- 1947 to Nov. 19 1947, and that I last saw him alive on Nov. 19 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 3 wks
Cerebellar Hemorrhage, not
Due to
Other Conditions Uremia.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address 5 W. Chase St. Date signed Nov 22 1947

correct age is especially important. Physicians: please write plainly.

V S 150

657145 STRITMATER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

657145 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General Hosp 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Stritmater

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 July 81

8. AGE: Years	Months	Days	If less than one day
66	4	9	hr. min.

9. Birthplace New York City (Town, county, or state)

10. Usual Occupation Retired Salesman

11. Industry or business

FATHER 12. Name Frederick Stritmater

13. Birthplace New York City

MOTHER 14. Maiden Name Margaret Koneen

15. Birthplace New York City

16 (a) Informant Mrs. Katherine Stritmater

(b) Address 1611 W. North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto Md.

18 (a) Funeral director Ingmire Brooks Lyfer

(b) Address 1600 W. North Ave.

19 NOV 21 1947 (Date rec'd by registrar) (b) Huntington Williamsport Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Nov 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Nov 1947 to 19 Nov 1947 and that I last saw he was alive on 19 Nov 1947.

	Duration
Immediate cause of death Cardiac Failure	2 days
Due to Arteriosclerotic heart disease	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Allgaier Lynch M.D.

Address Md. Gen. Hosp. Date signed 21 Nov 47

correct age is especially important. Physicians: please write plainly.

VS 150

557146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 557146

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 S. Eaton St.
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 S. Eaton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA ATZINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis Atzinger
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) April 6, 1880

8. AGE: Years	Months	Days	If less than one day
67	7	13	....hr. ....min.

9. Birthplace Bavaria, Germany
(Town, county, and state)
10. Usual Occupation House-Work
11. Industry or business At Home.

FATHER
12. Name Paul Moser
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Louis Atzinger Sr. (Husband)
(b) Address 613 S. Eaton St.

17 (a) Burial (b) Date thereof 11-22-47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cemetery
Location German Hill Rd. Balto. Co. Md.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 901 S. Conkling St.

19 (a) NOV 21 1947 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1947, at 10:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1947 to Nov 19 1947, and that I last saw her alive on Nov 19 1947.

Immediate cause of death	Duration
Carcinoma of Larynx Metastasis.	1947
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Oct 17-47
Major findings of operation: Carcinoma of Larynx
of autopsy: to Liver -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Irvin F. McGinnis M. D.
Address 3426 Bank St. Date signed Nov 20-47

X

Write the entries on this certificate in ink. Physicians: please write correct age is especially important.

V S 150.

G57147 B-4383 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 9

Registered No. G57147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 E. 20th Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ilona Fisher ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1946

8. AGE: Years	Months	Days	If less than one day
1	6	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James Fisher.
13. Birthplace Greenwood, S.C.

MOTHER
14. Maiden Name Ethel Walker.
15. Birthplace Laurence, S.C.

16 (a) Informant Ethel Fisher
(b) Address 28 E. 20th Ste.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22, 1947. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) NOV 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1947, at 10 a.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pertussis
Subarachnoid hemorrhage
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11/20/47

VS 151

G57148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 108

Registered No. G57148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2753 Bookert Drive
(c) Hospital or institution: Home. 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2753 Bookert Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Bush ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Widowed

6 (b) Name of husband or wife Rebecca Bush
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1853

8. AGE: Years	Months	Days	If less than one day
94	4	1	hr. min.

9. Birthplace Talbert County, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name not Known.
13. Birthplace Not Known.

MOTHER
14. Maiden Name Mary Ann Peeker
15. Birthplace Talbert County

16 (a) Informant Emily Collins
(b) Address 2753 Bookert Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 NOV 21 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17, 1947, at 1120 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16, 1947 to Nov 17, 1947 and that I last saw him alive on Nov 17 1947.

Immediate cause of death I	Lobar Pneumonia	Duration
Due to	Acute Infection	
Due to	Sen	
Other Conditions	Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerry C. Leuck M. D.
Address 303 Bridgeview Rd. Date signed 11-17-47

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

G57149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G57149
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-1
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 N. Legrey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ELIZABETH ROBINSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Sterling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name Wash Lewis
13. Birthplace Va.

MOTHER
14. Maiden Name Emma ?
15. Birthplace Va

16 (a) Informant Sterling Robinson
(b) Address 609 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. E. Kelson
(b) Address 1363 Lafayette Ave

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17/47 19..., at 11:57 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to Hypertensive Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Lewis M.D.
Medical Examiner.
Date signed 11/18/47

7150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 652150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1893 E. Balto. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Rosenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1877

8. AGE: Years: 70 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Unknown

MOTHER
14. Maiden Name —
15. Birthplace Unknown

16 (a) Informant: Harry Rosenberg
(b) Address: 1833 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-47 (month) (day) (year)
(c) Cemetery or crematory: Arlington Cem.
Location:

18 (a) Funeral director: Jack Levine Inc
(b) Address: 2100 Eutaw Place

19 (a) NOV 21 1947 (Date rec'd by registrar) (b) Arrington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1947, at 5:15 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1947 to 11/20 1947, and that I last saw h[illegible] alive on 11/20 1947.

Immediate cause of death	Duration
Carcinoma of stomach	
Cachexia	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operations:	
of autopsy: Carcinoma of stomach & metastasis	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Samson M. Mann M. D.
Address: Sinai Hosp Date signed 11/21/47

correct age is especially important. Physicians, please

X

57151 B.C.# 2-7614 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √55E

Registered No. 57151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 N. Linwood Ave
(c) Hospital or institution: 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Melody Paige Quade

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married, widowed~~, or ~~divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 16th 1947

8. AGE: Years | Months: 7 | Days: 4 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Quade
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Norma Airey
15. Birthplace Balto. Md.

16 (a) Informant Joseph Quade
(b) Address 23 N. Linwood Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/5/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Balto. "
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

Correct age is especially important.

VS 139

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20th 1947, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 16 1947, to Nov. 20 1947 and that I last saw h[er] alive on Nov. 20 1947.

Immediate cause of death: Lympho-Sarcoma — Duration: Since birth
Due to: ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Williams M.D.
Address 1732 N. Broadway Date signed 11/21/47

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

57152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

Registered No. G57152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3032 Guilford Avenue
(c) Hospital or institution: 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3032 Guilford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reese Scourfield

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widowed

6 (b) Name of husband or wife Gwennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1874

8. AGE: Years	Months	Days	If less than one day
73	8	25	hr. min.

9. Birthplace Ohio
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Scourfield
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Elizabeth Price
15. Birthplace Pennsylvania

16 (a) Informant H. E. Morgan
(b) Address 3032 Guilford Avenue

17 (a) removal (b) Date thereof Nov 21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Sherrodsville, Ohio

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 21 1947 (b) Huntington Nelligan, M.D.
(Date rec'd by registrar) Registrar

correct age if impossible otherwise

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1947 at 7 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1947 to Nov 21 1947, and that I last saw him alive on Nov 20 1947.

Immediate cause of death	Duration
Uraemia	5d
Broncho Pneumonia	2d
Due to Chronic Arteriosclerosis	24y
Due to Chronic Interstitial Nephritis	24y
Other Conditions Chronic arthritis deformans	15y

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. A. Stevens M. D.
Address 2878 Hartford Ave Date signed 11-21-47

X

G57153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G57153 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Madison Street 14-4
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 HAMSAY STREET
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Louis Ruland

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-09-2639

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Lydia Ruland
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct-9-1878

8. AGE: Years	Months	Days	If less than one day
69	1	11	hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Night Supervisor
11. Industry or business: Hutzler Bros.

FATHER
12. Name: Not Known
13. Birthplace: Germany

MOTHER
14. Maiden Name: Not Known
15. Birthplace: " "

16 (a) Informant: Mr. L. J. Ruland (son)
(b) Address: Milford (nr Pikesville, Md.)

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Nov-24-1947 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore

18 (a) Funeral director: Stewart & Mowen Co.
(b) Address: 108 W-North-Av., City.

19 (a) NOV 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1947, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1947, to Nov. 20 1947, and that I last saw him alive on Nov. 20 1947.

Immediate cause of death: Cardiac failure — Duration:
Due to: Cardiac Decompensation
Due to: Myocardial Degen. Coronary Artery Disease
Other Conditions: Lobar Pneumonia
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Edward Burkhardt
Address: Md. Grad Hosp. Date signed 11/20/47

correct age is especially important. Physicians: please write the CAUSES OF DEATH clearly and legibly.

VS 150

94a

G57154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57154 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette + Calhoun
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4423 Harcourt Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank M. Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Harriet Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21-1887

8. AGE: Years 60 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired Police

11. Industry or business

FATHER
12. Name George Fisher
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Engel
15. Birthplace Md.

16 (a) Informant Mrs. Harriett Fisher
(b) Address 4423 Harcourth Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto.

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd.

NOV 21 1947 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1947, at 3.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1947, to 11-21 1947, and that I last saw him alive on 11-21 1947.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerotic heart disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq. Hosp. Date signed 21 Nov 47

VS 150

G57155 Dr. Bagse

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4527 Mainfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4527 Mainfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET G. ABELS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles H. Abels
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1867

8. AGE: Years	Months	Days	If less than one day
80	3	30	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Grimmel
13. Birthplace Berlin

MOTHER
14. Maiden Name Katherine Born
15. Birthplace Germany

16 (a) Informant Mrs. Raymond Abels
(b) Address 4527 Mainfield Avenue, 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) NOV 21 1947 (Date rec'd by registrar) (b) Registrar

correct age is especially important. Physicians: please write

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20th, 1947, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May, 1946 to Nov. 1947, and that I last saw her alive on Nov. 19 1947

Immediate cause of death Cerebral hemorrhage — Duration 3 hrs.
Due to Arteriosclerotic hypertension
C.V.D.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry Stone
Address 1118 Hanford Rd. Date signed 11/21/47 M. D.

57156 Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 657156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4200 Parkwood Avenue
(c) Hospital or institution: 26-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Parkwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Valentina Josephine Sevcik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Vincent Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 18th, 1892

8. AGE: Years	Months	Days	If less than one day
55	8	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Charles Werner
13. Birthplace Bohemia

MOTHER
14. Maiden Name Johanna Peshek
15. Birthplace Bohemia

16 (a) Informant Mrs. Vincent J. Sevcik
(b) Address 4200 Parkwood Avenue

17 (a) Burial (b) Date thereof 11-21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

1947 NOV 21 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18th, 1947, at 4:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946, to Nov. 1947, and that I last saw her alive on Nov. 16 1947

Immediate cause of death Cerebral hemorrhage — Duration 2 hrs.

Due to Hypertension C.V.D.

Due to Progressive degeneration Myocardium Bronchitis of pulmonary system

Other Conditions Multiple sclerosis ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: M.M.

6-1 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Harry Hasse M. D.
Address 4218 Harford Rd. Date signed 11/19/47

correct age is especially important. Physicians: please write plainly.

VS 150

X

G57157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 E. 20th street
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 E. 20th street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A. WYNN

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1863

8. AGE: Years	Months	Days	If less than one day
84	1	18	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Floor-lady
11. Industry or business Gent's Shirt Factory

FATHER
12. Name Thomas M. Wynn
13. Birthplace Ireland

MOTHER
14. Maiden Name Jane Hanley
15. Birthplace Ireland

16 (a) Informant Miss Katherine L. Wynn
(b) Address 523 E. 20th street

17 (a) Burial (b) Date thereof Nov. 22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans, Inc.
(b) Address 118 N. Mt. Royal Ave

19 NOV 21 1947 (b) Huntingtown, Md.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1947 to 11-19 1947, and that I last saw h. 6e. alive on 11-19 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio Vascular Disease	5 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature P.D. Flynn M. D.
Address 11 E. Chase St Date signed 11-20-47

correct age is especially important. Physicians: please write

X

G57158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G57158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Broadway
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N. Milton Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Fornoff (WILLIAM FORNOFF, JR.)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	M

6 (b) Name of ~~husband~~ or wife Mrs. Minnie Fornoff
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1887

8. AGE: Years	Months	Days	If less than one day
60	3	16	..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Retired paper hanger
11. Industry or business

FATHER
12. Name William Fornoff
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Haddaway
15. Birthplace Talbot Co. Md.

16 (a) Informant Mrs. William Fornoff
(b) Address 508 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/47 (month) (day) (year)
(c) Cemetery or crematory LORRAINE CEMETERY
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) NOV 22 1947 (Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1947, at 7.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1947 to Nov. 14 1947 and that I last saw him alive on Nov. 19 1947.

Immediate cause of death pulmonary edema — Duration 4 hrs

Due to Cardiac Insufficiency — 2 yrs

Due to Rheumatic Heart Disease Inactive — 40 yrs

Other Conditions Cardiac Enlargement Mitral Stenosis + Incompetency
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Aortic Stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lee M. Howard M. D.
Address Church Home Hospital Date signed 11/19/47

correct age is especially important, and any amendment, please

VS 150

57159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 657159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 12-2
(d) Length of stay in hospital or inst. (yrs., days) 24
(e) Length of stay in Baltimore (yrs., days) 80

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Blackstone Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Holt Richardson

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed or divorced:

6 (b) Name of husband or wife: Elizabeth (Nitzel)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-27-67

8. AGE: Years 80 | Months 8 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Attorney

11. Industry or business

FATHER — 12. Name Caleb Richardson

13. Birthplace Maryland

MOTHER — 14. Maiden Name Mary A. Hawkins

15. Birthplace Maryland

16 (a) Informant Standley L. Richardson

(b) Address 5122 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery

Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) NOV 25 1947 (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1947, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from November 1 1947, to November 20 1947, and that I last saw him alive on Nov. 20 1947.

Immediate cause of death: Heart failure — Duration

Due to Arteriosclerotic Heart Disease —

Due to

Other Conditions Chronic Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Standley L. Richardson

Address Union Memorial Hospital Date signed 11/24/47 M. D.

VS 150

Physicians: please write the causes of death in ink. Be sure that the information you give is correct and complete. Accuracy is especially important.

G57160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Boston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Boston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Zinkand

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife Lizzie Ella B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 187?

8. AGE: Years	Months	Days	If less than one day
70	2	24	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Grocers.
11. Industry or business

FATHER
12. Name Frank Zinkand
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Trutter
15. Birthplace Germany

16 (a) Informant Rose A Lantz
(b) Address 3405 Boston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John C. Mozan
(b) Address 5000 E Baltimore St

19 NOV 21 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1947; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1945, to Nov 20 1947, and that I last saw him alive on Nov 20 1947

Immediate cause of death	Duration
Chr. Myocarditis	
Coronary Disease Nov 20	47
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Krettman M. D.
Address 3426 Bank St Date signed 11/20/47

Correct age is especially important if a pension claim is involved.

VS 150

X

G57161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G57161 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3701 Woodbine Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State 2nd (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Woodbine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward McGee

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elsa G. McGee
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar 21/1885

8. AGE: Years	Months	Days	If less than one day
62	7	30	hr. min.

9. Birthplace Minneapolis Minn
(Town, county, and state)
10. Usual Occupation Flour Broker
11. Industry or business Eagle Roller Mill Co.

FATHER
12. Name Owen McGee
13. Birthplace Wis

MOTHER
14. Maiden Name Harriet Donelly
15. Birthplace Wis.

16 (a) Informant Elsa G. McGee
(b) Address 3701 Woodbine Ave

17 (a) Burial (b) Date thereof Nov 25/1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Mary
Location Minneapolis Minn

18 (a) Funeral director Harry J Amacker
(b) Address 420 Reedwood St

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar)

NOV 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1947, at 11:30 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelbach (M.D.)
Medical Examiner.
Date signed Nov 20, 1947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

657162 / X 657162 Registered No. 1321a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6107 Spencer Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER N. HARPER

3 (b) If veteran, name war

3 (c) Social Security Account No. 080-20-8185

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen Harper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Febuary 18 1894

8. AGE: Years 53 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Troy New York (Town, county, and state)

10. Usual Occupation Civil Engineer

11. Industry or business War Department

FATHER
12. Name Robert Y. Harper
13. Birthplace Troy New York

MOTHER
14. Maiden Name Frances D. Walker
15. Birthplace Windham New York

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Kenseco Cemetery
Location West Chester Co. N. Y.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Avenue

19 (a) NOV 22 1947 Washington for Williams, M.D. Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1947, at 8.50 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary edema
Coronary arteriosclerosis
Due to Arteriosclerotic cardio-vascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11-21-47

X

7163
AF-107825

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 057163

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9mos-29days
(e) Length of stay in Baltimore (yrs., mos., or days) 9mos-29days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Queen Anne's
(c) City or town Chester
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Orem Gardner Jr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23- 1928

8. AGE: Years	Months	Days	If less than one day
19	7	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Orem Gardner
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Bradshaw
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24-47 (month) (day) (year)
(c) Cemetery or crematory Stevensville
Location Stevensville Md

18 (a) Funeral director Edgar L. Lane
(b) Address Chester Town Hall Md

19 (a) Nov 22 1947 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21- 1947, at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 19 47, to 11-21 19 47, and that I last saw h. alive on 11-21 19 47

Immediate cause of death	Duration
Acute Heart Failure (Post-operative)	
Due to Obstructive Surgery and Pneumonia	
Due to Thrombosis after Operation	
Other Conditions Pulmonary Tbc Left U.L. (Include pregnancy within 3 months of death)	

Date of operation 11-21-47
Major findings of operation: Pulmonary Tbc
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 11-21-47 at 2:30 PM
(c) Where did injury occur? East City Hospitals (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work?
(e) Means of injury Thrombosis after Operation under Industrial Code Pneumonia
23. Signature A. Butler M. D.
Address East City Hosp Date signed 11-21-47

Correct age is supremely important. Try to get it.

V S 150

To be Approved by Medical Examiner

7164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 96

Registered No. 657164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Perryville Cecil County
(c) City or town.....
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Isaac Leonard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Color or race	5. Sex	6 (a) Single, married, widowed, or divorced.
Negro	Male	Sep.

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
39			..... hr. ..... min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name George Leonard
13. Birthplace ?

MOTHER 14. Maiden Name Florence Bridgewater
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11 | 24 | 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Franklin
Location Castleton Md.

18 (a) Funeral director Hubert P. Watkins
(b) Address Delta, Pa.

19 (a)..... (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

NOV 22 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1947 at 1.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1947 to Nov 20 1947 and that I last saw h[illegible] alive on Nov 20 1947.

Immediate cause of death	Duration
Acute Bacterial Endocarditis due to B. Hemolytic Streptococcus Group C. with Embolic Nephritis and Uremia	
Due to Pneumothorax into pleural Cavity due to Ruptured mycotic aneurysm of mesenteric vessel	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Truman G. Clapham M. D.
Address Johns Hopkins Hosp. Date signed 11-21-47

057165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 057165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Ashland Avenue
(c) Hospital or institution: 71

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Ashland Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kusiak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna (nee Shulans)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1889

8. AGE: Years	Months	Days	If less than one day
58	9	5	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Anthony Kusiak
13. Birthplace Poland

MOTHER
14. Maiden Name Eva Paska
15. Birthplace Poland

16 (a) Informant Mrs. Anna Shulans Kusiak
(b) Address 2814 Ashland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) NOV 22 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1947, at 12 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1943 to Nov 20 47 and that I last saw [illegible] alive on Nov 20 1947

Immediate cause of death Coronary Thrombosis — Duration 11 hrs 1943
Due to Ch. Myocarditis — 1/3/43
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William F. Kramer M.D.
Address 801 Kenilworth Dr Date signed 11/24/47

correct age is especially important. Physicians, please

VS 190

657166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 657166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3330 Fairfield Rd (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Daniel JENNINGS

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-9861

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
80			....hr. ....min.

9. Birthplace a.a. co md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Daniel Jennings
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Bradford
15. Birthplace md.

16 (a) Informant Mary White
(b) Address 920 N. Stricker St

17 (a) Burial (b) Date thereof Nov 22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location.....

18 (a) Funeral director James A Stamos
(b) Address 1874 2 Wolfe St

19 (a) NOV 22 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1947, at 9" A.M.

21. I certify that I took charge of the remains described above, held an Inspection by thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11/20/47

X

57167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 057167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp Women of Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2332 N Charles St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Louise Nagle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	wh.	W. dowed

6 (b) Name of husband or wife Chas J Nagle

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) 1 - 26 - 1868

8. AGE: Years	Months	Days	If less than one day
79	9	25	____ hr. ____ min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thos H. Reese
13. Birthplace Phila Pa

MOTHER
14. Maiden Name Amelia Haney
15. Birthplace Va

16 (a) Informant Capitola Reese
(b) Address 2332 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Bateman Lore
(b) Address 2324 N Charles St

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) NOV 22 1947 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 20 - 1947, at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov - 19 - 1947, to Nov - 20 - 1947, and that I last saw h[illegible] alive on Nov - 20 - 1947.

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Arteriosclerotic Hr. Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George T. Jeffreys M. D.
Address Hosp Women Md Date signed NW-21-47

correct age is especially important. Physicians: please write

VS 150

X

57168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G57168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Cabut Sts, Balto.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Monkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** S. Lurman Stewart

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. S. Lurman Stewart
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 10-29-82

8. AGE: Years	Months	Days	If less than one day
65	0	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles Morton Stewart
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Josephine Lurman
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs S. Lurman Stewart
(b) Address Monkton, Md.

17 (a) Burial (b) Date thereof Nov 22 1947
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory St Thomas'
Location Garrison Forest Md

18 (a) Funeral director Henry W. Jenkins Sons
(b) Address Mt. Carroll & Orchard Sts

19 NOV 22 1947 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1947 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1947 to 19, and that I last saw him alive on 19

Immediate cause of death	Duration
Pulmonary embolism	
Due to Operation following	
Due to Thrombosis Mesenteric at C.L.	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)
Date of operation Nov 15. 1947
Major findings of operation: Carcinoma of end
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Nov 18 47 at M
(c) Where did injury occur? On Farm at 9 mi (County) Balto.
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? Yes
(e) Means of injury Fell from Tree
23. Signature
Address Date signed 19

VS 150

correct age is especially important. Physicians: please write

57169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 052169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1750 Homestead St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1750 Homestead St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose E Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of husband ~~or wife~~: Joseph E Ford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1876

8. AGE: Years 71 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Gallagher
13. Birthplace Ireland

MOTHER
14. Maiden Name B. Burk
15. Birthplace Ireland

16 (a) Informant Joseph E Ford
(b) Address 1750 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John E Moran
(b) Address 3000 E Baltimore St

NOV 22 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1947 to 11/21 1947 and that I last saw h~~er~~ alive on 11/20 1947.

Immediate cause of death	Duration
Myocardial Failure	
Due to Hypertension	
Due to Uremia acute	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A E Thompson M. D.
Address 1123 St. Paul St Date signed 11-21-47

VS 150

657170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 657170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2410 W. Rogers Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2410 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT BURGUNDER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mazie Ferst Burgunder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1893.

8. AGE: Years	Months	Days	If less than one day
54	1	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Burgunder,
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Rose Bernei,
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mazie F. Burgunder,
(b) Address 2410 W. Rogers Ave.

17 (a) Burial (b) Date thereof 11/23/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Morris Levine
(b) Address 1902 Eutaw Place.

19 (a) [illegible] (b) Huntington Williams, M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20th, 1947 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1935 to Nov. 20, 47 and that I last saw h im alive on Nov. 12 1947

Immediate cause of death	Duration
Coronary thrombosis	5 min.
Due to Coronary sclerosis	
symptoms	12 yrs.
Due to	
Other Conditions Multiple myocardial infarcts	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
Coronary thrombosis
of autopsy Multiple myocardial infarcts

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, state in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Place. Date signed

correct age is especially important. Physicians, please write plainly.

VS 150

657171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 657171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address White Park Apts. Park Ave. & Whitelock St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 1
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltmore
(If outside city or town limits, write RURAL and give town)
(d) Street No. White Park Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME RENA ROSENBERG.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1873.

8. AGE: Years	Months	Days	If less than one day
74	10	1	hr. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Michael Rosenberg,
13. Birthplace Germany.
14. Maiden Name Julia Keyser,
15. Birthplace Balto. Md.

16 (a) Informant Miss. Fannie Rosenberg,
(b) Address White Park Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/47. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Burial Association of Lower
(b) Address 1902 Eutaw Place.

NOV 22 1947 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20th. 19 47 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 19 47 to 11/20 19 47, and that I last saw h[illegible] alive on 11/20 19 47

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to General arteriosclerosis — Duration [illegible]

Due to Fracture of upper [illegible] — Duration 1947

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Feb 17, 1947 at M
(c) Where did injury occur? Lenox Hall Balto Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No
(Specify type of place)
(e) Means of injury Fall in home

23. Signature Howard J. Tilghman M. D.
Address 2320 Eutaw Place Date signed

Howard J. Tilghman, M.D.

correct age is especially important. Physicians: please write

VS 150

57172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 057172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home + Hospital
(c) Hospital or institution:
Broadway + Fairmont 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mon.
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 78

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Mt Royal Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Edith Grace Rice

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1868

8. AGE: Years	Months	Days	If less than one day
79	0	28	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation Retired Teacher
11. Industry or business Dept. Education Balto. City

FATHER
12. Name John Rice
13. Birthplace England

MOTHER
14. Maiden Name Eliza Needham
15. Birthplace England

16 (a) Informant Alfred C. Rice
(b) Address 210 Tuttle Rd.

17 (a) Cremation (b) Date thereof 11/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington, Williamsport, Md.
(Date received by local registrar)

NOV 28 1947

VS 150

correct age is especially important. Typewriter, preferred.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1947, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1942, to Nov 20 1942 and that I last saw her alive on Nov. 20 1947

Immediate cause of death	Duration
Malnutrition	2 Mon.
+ Hypostatic pneumonia	
Due to Chronic intestinal obstruction	4 mos.
Due to Carcinoma, Recurrent	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 7/24/47 9/18/47
Major findings of operation: Intestinal obstruction due to adhesions
of autopsy: Carcinoma, recto-sigmoid

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature T. Lacy Morrow M. D.
Address Church Home + Hosp. Date signed 11/24/47

X

57173

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 6512173

CERTIFICATE OF DEATH 49a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 64 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 344 Whitridge Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Clarence M. Shipley
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 10/6/1899

8. AGE: Years	Months	Days	If less than one day
48	1	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Mathew J. White
13. Birthplace Ireland.

MOTHER
14. Maiden Name Delia Garvey
15. Birthplace Ireland.

16 (a) Informant Husband
(b) Address 344 Whitridge Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location CITY

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREEN MOUNT & 22ND

19 (a) 11/23/47 (Date rec'd by registrar) (b) Transit or Hollingsworth Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1947, at 3 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18/1947 to 11/21/1947 and that I last saw h.e.r. alive on 11/21/1947.

Immediate cause of death Cachexia — Duration

Due to Generalized Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony F. DiPaula M.D.
Address St. Joseph's Hosp. Date signed 11/21/47

correct age is especially important. Exactness . . .

VS 150

X

57174

392107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133D

Registered No. G57174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 W. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis X. Powell

3 (b) If veteran, name war

3 (c) Social Security Account No. 099-09-7139

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	MARRIED —

6 (b) Name of husband or wife JULIA R. POWELL

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 4/29/99

8. AGE: Years	Months	Days	If less than one day
49	6	2?	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation electrician

11. Industry or business

FATHER — 12. Name F. X. Powell

13. Birthplace ?

MOTHER — 14. Maiden Name Nellie Tooley

15. Birthplace Ireland

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof 11-24-47 (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL

Location CITY

18 (a) Funeral director WIEDEFELD & SON

(b) Address GREENMOUNT AVE & 22ND ST.

19 (a) (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21 1947, at 2:27 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 1947 to 11/21 1947 and that I last saw him alive on 11/21 1947

Duration
Immediate cause of death: Cardiac failure — Interval
Due to: hypertension — Contrib.
Due to: renal disease — 10 years
Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peter L. Scardina M. D.

Address Johns Hopkins Hospital Date signed 11-31-47

correct age is especially important. If uncertain, give approximate age.

VS 150

X

G57175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

Registered No. G57175

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6506 Fait Ave.
(c) Hospital or institution:
None
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6506 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES B. ASHBURN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary (nee Russell)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	4	hr. min.

9. Birthplace Unk.
(Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business Produce

FATHER
12. Name Unk.
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John P.F.Donlin - Lawyer
(b) Address Dundalk & Patapsco Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Avenue Inc.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe Street

19 (a) NOV 22 1947 (b)
(Date received by registrar)

V S 150

correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Nov 21 1947, and that I last saw h[illegible] alive on Nov 20 1947.

Immediate cause of death	Duration
Uremia	1 wk
Due to Arteriosclerosis	5 yrs
Due to Chronic nephritis Hypertension	2 yrs. 2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury.

23. Signature David H. Andrew M.D.
Address Kenilworth Rd Dundalk Md Date signed 11/22/47 M. D.

57176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G57176 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Gibbons (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pasquale Muscati

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife Rosetta —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/17/82

8. AGE: Years	Months	Days	If less than one day
65	1	3	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Tailoring

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant wife
(b) Address 3305 Gibbons

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 24 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St.

19 (a) NOV 22 1947 (Date rec'd by Registrar) (b) Thurston Wilkinson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1947 at 1 35 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11/4/47 19 to 11/21/47 19 and that I last saw him alive on 11/21/47 19

Immediate cause of death: Cardio-Respiratory failure — Duration
Due to Toxemia
Due to Hypostasis a Pulmonary Embolism
Other Conditions: Resection of Sigmoid

(Include pregnancy within 3 months of death)
Date of operation 11/12/47
Major findings of operation: Ca Sigmoid
of autopsy: denied

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Bailey M.D.
Address 1400 Caroline Date signed 11/21/47

correct age is especially important. Typewriting is required.

557177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

Registered No. 557177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or Institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert
(c) City or town Huntingdon (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Richard Gibson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-25-47

8. AGE: Years	Months	Days	If less than one day
-	-	3 wks	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name Franklin Gibson
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances Bathler
15. Birthplace Maryland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Calvary
Location Huntingtown

18 (a) Funeral director O. A. Hellmann & Son
(b) Address Mutual, Md

19 (a) NOV 22 1947 (Date rec'd by registrar) (b) Huntingtown, Williams, MD

COPIES [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1947, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1947 to Nov 21 1947 and that I last saw h.im alive on Nov 21 1947

Immediate cause of death	Duration
Toxemia	
Due to Epidermolysis Bullosa	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.....

23. Signature P. K. Sahler M.D.
Address Johns Hopkins Hospital Date signed 11/22/47

G57178 BALTIMORE CITY HEALTH DEPARTMENT G57178

CERTIFICATE OF DEATH

161a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: South Balto Genl Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 11 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 316 Church St. Brooklyn
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Leshowicz

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-21-47

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day: 11 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Edwin Lechowicz
13. Birthplace

MOTHER
14. Maiden Name Kalevoda
15. Birthplace

16 (a) Informant Father
(b) Address same

17 (a) Burial (b) Date thereof 11/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location G.A.Co. Md

18 (a) Funeral director Flynn & Flannery
(b) Address 1016 Light St.

19 (a) 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 1947 at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6 PM 11-7-1947, to 6:25 PM 11-21-1947, and that I last saw him alive on 11-21-1947.

Immediate cause of death: Acute Respiratory Failure — Duration:

Due to: Ectasis of The New-born — Duration:

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Sullivan M.D.
Address S.B.G.H. Date signed 11/22/47

VS 150

X

Physicians: please write the cause of death in terms which are specially important. Please write the cause of death in terms which are specially important.

G57179 ✓ G57179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Main St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Newton Uhler

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1859

8. AGE: Years	Months	Days	If less than one day
88	0	22	hr. min.

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation Railroad Laborer
11. Industry or business —

FATHER
12. Name Andrew Uhler
13. Birthplace —

MOTHER
14. Maiden Name Mary Ryland
15. Birthplace —

16 (a) Informant Mrs. Irvin Palmer
(b) Address 3 Cuffle Rd. Reisterstown Md

17 (a) Burial (b) Date thereof Nov. 25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory All Saints
Location Balto Co

18 (a) Funeral director J. F. Elgin & Sons
(b) Address Reisterstown Md

28 (a) 1947 (b) Registrar for Nitinat, Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1947 at 1:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1947 to Nov 22 1947 and that I last saw h[illegible] alive on Nov 22 1947

Immediate cause of death Cerebral Hemorrhage — Duration 2 days
Due to Generalized arteriosclerosis — 15 yrs
Due to —
Other Conditions Arterio-sclerotic gangrene, left leg — 3 months
(Including pregnancy within 3 months of death)
Date of operation Oct 17, 1947
Major findings of operation: Arterio-sclerosis, advanced
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —
23. Signature Eleanor P. Brown M. D.
Address Union Memorial Hospital Date signed Nov 22 1947

Do not write in this space is especially important. Physicians: please write clearly and use ink.

VS 150

G57180

229438

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G57180
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 Winterbourne Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Fleischmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed or divorced~~: married

6 (b) Name of husband or wife: Dr. Walter Fleischmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/99

8. AGE: Years 48 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Julius Fodor
13. Birthplace Hungary

MOTHER
14. Maiden Name Farda Adler
15. Birthplace Austria

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11/25/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

(c) NOV 23 1947 (Date rec'd by registrar) (d) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1947 at 2215 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1947 to 11/22 1947 and that I last saw ~~him~~ her alive on 11/21 1947

Immediate cause of death	Duration
metastatic carcinoma	3 yrs
Due to carcinoma of breast	18 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1930
Major findings of operation: metastatic lesions of lymph nodes,
of autopsy: brain, etc.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Bisson M. D.
Address J. Hop. Hospital Date signed 11-23-47

correct age is especially important for persons under one year of age

VS 190

G57181 **BALTIMORE CITY HEALTH DEPARTMENT** G57181
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution: 8'
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1739 N. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Friese

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife George Friese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 1879

8. AGE: Years	Months	Days	If less than one day
68	7	15	hr. min.

9. Birthplace Mercersburg, Pa. (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business Self

FATHER
12. Name Unknown
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Unknown Unknown
15. Birthplace Unknown

16 (a) Informant Andrew Jackson
(b) Address 1739 N. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Wm. Cook Sons
(b) Address 1217 St. Paul St.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

NOV 23 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1947, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1947, to Nov. 21 1947, and that I last saw her alive on Nov. 21 1947.

Immediate cause of death Chronic myocarditis and myocardial degeneration — Duration 4 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ed Donaldson M. D.
Address 1250 E. Preston Date signed Nov. 24 1947

X

Copies are not acceptable

G57182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G57182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U S Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Marshall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bryant, James Warren

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. 218-14-3541

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary J. Bryant
6 (c) If alive, give age not given

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1897

8. AGE: Years 50 | Months 10 | Days 16y | If less than one day ____hr. ____min.

9. Birthplace Calvert Co. Md, U. S. A.
(Town, county, and state)

10. Usual Occupation Self-employed

11. Industry or business ~~not given~~ Carpentering

FATHER
12. Name Sid Bryant
13. Birthplace Virginia

MOTHER
14. Maiden Name ~~Unknown~~ Maggie Barnes
15. Birthplace ~~Virginia~~ Calvert Co. Md.

16 (a) Informant Records, U. S. Marine Hospital
(b) Address Wyman Park Drive, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery ~~cemetery~~ Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

correct age is especially important. Typewriting preferred.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1947, at 11:35PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1947 to Nov. 21 1947 and that I last saw h 1m alive on Nov. 21, 1947.

Immediate cause of death Hypertensive vascular disease; Cerebral hemorrhage — Duration: 1 day

Due to ____

Due to ____

Other Conditions ____
(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature Clyde H. Dabbs
Clyde H. Dabbs, Asst Surg. M. D.
Address Officer of the Day Date signed 11-22-47

V S 1947

Washington Williams, M.D.

G57183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G57183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 N. Eutaw
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 N. Eutaw
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Skinner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Charles Cornish

13. Birthplace md

MOTHER 14. Maiden Name Sarah —

15. Birthplace md

16 (a) Informant Sadie Ward

(b) Address 541 W. Hamburg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director James A Hayes

(b) Address 142 W Fred St

19 (a) (Date received by registrar) (b) Huntington Williams M.D.

NOV 25 1947

Correct age is especially important. Please see that it is correctly stated.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1947 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to Nov 20 1947, and that I last saw [illegible] alive on Nov 20 1947

Immediate cause of death: Carcinoma of stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Yrs. Mos. Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Garland Schmidt M. D.

Address 1534 Eutaw Date signed Nov. 21

G57184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G57184 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2407 Brookfield Ave
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Apt
(d) Street No. 2407 Brookfield Ave 2-B. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business: None

FATHER
12. Name: Harry Kellert
13. Birthplace: Russia

MOTHER
14. Maiden Name: Lena Shimberg
15. Birthplace: Russia

16 (a) Informant: Mrs Minnie Proper
(b) Address: 2407 Brookfield Ave Apt 2-B

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23, 1947 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship Cem
Location: 3600 E Baltimore St

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

(a) NOV 22 1947 registered (b) Registrar

V S 150

correct age is especially important. Typewriting, please.

MEDICAL CERTIFICATION 9.30

20. DATE OF DEATH November 21 1947, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jul 1930 to Nov 21 1947. and that I last saw h[illegible] alive on Nov 21 1947

Immediate cause of death	Duration
Acute Cardiac Dilatation	4 days
Due to Diabetes	15 yrs
Due to Chronic Cardio Vascular Dis	15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael A Abrams M. D.
Address 1820 Eutaw Place Date signed Nov 24 1947.

B.O.# 14129 G57185 A-5-822

BALTIMORE CITY HEALTH DEPARTMENT ✓ G57185 Registered No.

CERTIFICATE OF DEATH 55a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3613 Wabash, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gail Frame.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-28-47

8. AGE: Years | Months: 10 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Md. Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Frame
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Pearl Fried
15. Birthplace Balto Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Lane
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eastern Ave

19 (a) (Date received by Registrar) (b) Registrar

NOV 25 1947
VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 - 1947 at 3 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8- 1947 to 11-23-1947 and that I last saw her alive on 11-23-1947.

Immediate cause of death Lung metastases — Duration: Days

Due to Adrenal cortical tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Chanda Jr M. D.
Address Johns Hopkins Hosp Date signed 11-24-47

X

COPIES AGE IS CONFIDENTIAL AND MUST BE SO USED

G57186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G57186 Registered No. 82B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Northern Pkd
(c) Hospital or institution: Mount Convelescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hilda Meyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 84 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Bridget Meyer
(b) Address 4500 Prospect Circle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt Nat Israel
Location Northern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2460 Eutaw Place

NOV 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

correct age is especially important. Physicians, please write

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22- 1947, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1947 to 11/24 1947, and that I last saw h.CR alive on 11/24 1947.

Immediate cause of death	Duration
Cerebro vascular Thrombosis	1 wk
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify kind of place)
(e) Means of injury

23. Signature Louis Blum, M.D.
Address 2310 Eutaw Pl Date signed 11/24/47 M. D.

V S 150

X

BC# 4-7784

G57187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G57187

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1033 N. Kenwood Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 N. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Marguerite Marie Pulignani

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1947

8. AGE: Years	Months	Days	If less than one day
	6	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Dante J. Pulignani
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Marguerite McElroy
15. Birthplace Baltimore, Maryland

16 (a) Informant Parents
(b) Address 1033 N. Kenwood Avenue

17 (a) Burial (b) Date thereof 11/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) (b)
(Date received by registrar) Registrar

NOV 25 1947

VS 150

correct age is especially important. A typewriter should be used.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 19 47, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 19 47 to Nov 22 19 47, and that I last saw her alive on Nov 21 19 47.

Immediate cause of death	Duration
Lobar Pneumonia	1
	5
Due to Influenza	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S S A Stevens M. D.

Address 2878 Hanford Rd Date signed 11-23-47

X

G57188 BALTIMORE CITY HEALTH DEPARTMENT G57188
CERTIFICATE OF DEATH 120 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Born

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josh (Roth) Roots

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Caroline County Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Ann Willie Roots
15. Birthplace Md.

16 (a) Informant Edward Roots
(b) Address 500 W. Biddle St.

17 (a) (Burial, cremation, or removal) (b) Date thereof Nov 23 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Hylton and
(b) Address 918 Druid Hill Ave.

19 (a) Nov 23 1947 (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19/47 19 , at 7:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D.
Date signed 11/20/47 Medical Examiner.

G57189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G57189

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 647 Dunbarton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 647 Dunbarton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Conrad Schuppert

3 (b) If veteran, name war None

3 (c) Social Security Account No. 213-03-0066

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Norah T. Schuppert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24. 1876

8. AGE: Years 71 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace New Freedom Pa. (Town, county and state)

10. Usual Occupation Retired Meat Cutter

11. Industry or business Wheatleys Store

FATHER 12. Name Conrad Schuppert

13. Birthplace Germany

MOTHER 14. Maiden Name Sophia Bruch

15. Birthplace Germany

16 (a) Informant Mrs. Norah T. Schuppert

(b) Address 647 Dunbarton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1947 (month) (day) (year)

(c) Cemetery or crematory Old Zion Lutheran Cemetery

Location Reisterstown Md.

18 (a) Funeral director Edmund W. Coppling & Son

(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Pennington Williams M.D.

V S 50 1947 NOV 23

correct age is especially important. Typewrite or print plainly in ink.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1947 to Nov. 21 1947, and that I last saw h.i.m. alive on Nov. 20 1947

Immediate cause of death: Heart Failure — Duration:

Due to: Coronary Thrombosis

Due to: Arteriosclerotic Cardio-Vascular Disease

Other Conditions: Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature K. Krukerst M. D.

Address 2116 W. Pratt St. Date signed 11/24/47

X

Q571993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. Q57199

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 N. Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 80 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Ferdinand H. Linhard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emily Wilcox
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1866

8. AGE: Years	Months	Days	If less than one day
80	11	21	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired church organist
11. Industry or business

FATHER
12. Name Andrew J. Linhard
13. Birthplace Germany

MOTHER
14. Maiden Name Helena Feldhaus
15. Birthplace Germany

16 (a) Informant Ferd I. Linhard
(b) Address 215 Broadmoor Road

17 (a) Burial (b) Date thereof 11/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director K. W. Mears and Son
Address 805 N. Calvert Street

19 (a) (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1947, at 42 M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] to Nov 21 1947 and that I last saw h[illegible] alive on Nov 20 1947.

Immediate cause of death: Cardiac Dilatation — Duration 7 days
Due to Chronic Endocarditis — 8 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 3136 Woodbourne Ave Date signed Nov 24 1947

VS 150

corrected age is especially important. Physicians, please write

G57191

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95C

G57191 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2425 Maryland Avenue
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 79 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 Maryland Avenue
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Mary Myohl

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) July 17, 1868

8. AGE: Years	Months	Days	If less than one day
79	4	3 4	....m. ....hr. ....m. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name Charles Myohl
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Schuster
15. Birthplace Maryland

16 (a) Informant Paul J. Kesmodel
(b) Address Severna Park, Md.

17 (a) Burial (b) Date thereof 11/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 (a) Date rec'd by registrar 12 1947 (b) [illegible]

VS 150

correct age is especially important. Punctuation, paragraphing, and capitalization should be observed.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 1947, at ....M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1- 1947 to 11-21- 1947, and that I last saw her alive on 11-21- 1947.

Immediate cause of death Acute Cardiac Dilatation 2 hrs. — Duration

Due to

Due to Hypertension several years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ....While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert C Blake M. D.
Address Md. Ave. Bldg. Date signed 11-22-47

X

G57192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 83a

G57192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Cutow Ave.
(c) Hospital or institution: Jenkins Memorial V.T.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5801 Halwyn Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME MRS MARY ELLEN JAMIESON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wm Hartley Jamieson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 7-1860

8. AGE: Years	Months	Days	If less than one day
about 84	6 —	15 —	— hr. — min.

9. Birthplace Quebec, Canada (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Tierner
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Morris
15. Birthplace Albany N.Y.

16 (a) Informant William C. Jamieson
(b) Address 5801 Halwyn Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) [redacted] (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1947, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19— to 19—, and that I last saw h— alive on 19—.

Immediate cause of death	Duration
Cerebrovascular Accident (Hemorrhage)	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Hypertrophic Arthritis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos. J. D'Alessandro M. D.
Address St Agnes Hospital Date signed 11-24-47

correct age is especially important. Physicians, please

VS 150

G57193 (struck) G57193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G57193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski Sts.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 Hollins St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Maria Cipra

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 216-09-9617

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife: Mrs. Elizabeth Cipra
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 9/16/1900

8. AGE: Years	Months	Days	If less than one day
47	2	7	hr. min.

9. Birthplace: Czechoslovakia (Town, county, and state)
10. Usual Occupation: Bartender
11. Industry or business: Business.

FATHER
12. Name: Alois Cipra
13. Birthplace: Czechoslovakia

MOTHER
14. Maiden Name: Uplenova
15. Birthplace: Czechoslovakia

16 (a) Informant: Elizabeth Brooks Cipra
(b) Address: 2000 Hollins Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-47 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore Maryland

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Ave. Baltimore, Md.

19 (a) [illegible] registrar [illegible] Registrar

correct age is eligibly important

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1947, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1947, to 11/23 1947, and that I last saw h[illegible] alive on 11/23 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to General metastasis	
Due to Carcinoma of unknown origin	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/17/47 Exploratory
Major findings of operation: Extensive metastasis with carcinoma of peritoneum, liver, & kidney
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: James A. Carey Jr. M. D.
Address Bon Secours Hospital Date signed 11/27/47

X

G57194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57194 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ST. KATHERINE CONVENT E. PRESTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Onesimus

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/16/1864

8. AGE: Years	Months	Days	If less than one day
83	- 2	- 5	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Edward Murphy
13. Birthplace Mayo Co. Ireland

MOTHER
14. Maiden Name Alice Simlin
15. Birthplace Mayo Ireland

16 (a) Informant Sr. M. Archangela
(b) Address E. Preston St. St Rose

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24th 1937 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Cook
(b) Address 1201-03 N. Patterson Park ave

19 (a) (b)
(Date received by registrar) Registrar

NOV 26 1937
VS 150 Huntington Williamsville, Md

correct age is especially important. Typewriter preferred.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21 1937 at 9 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 1937 to 11/21 1937, and that I last saw her alive on 11/21 1937.

Immediate cause of death	Duration
Congestive heart failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address 1400 N. Caroline St. Date signed 11-21-37

X

657195 Registered No. X 657195

Medical Examiner's Case 1226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Texas
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Carrenshaw

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-1903

8. AGE: Years 44 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Balto Co. Roads

FATHER 12. Name Irving Crenshaw

13. Birthplace Va

MOTHER 14. Maiden Name Sallie Phillips

15. Birthplace Va

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25-47 (month) (day) (year)

(c) Cemetery or crematory Gough's

Location Cuba Road, Cockeysville

18 (a) Funeral director Landon M. Brown

(b) Address Sparrows, Md

19 (a) (Date rec'd by registrar) Nov 23 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1947, at 4 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1947 to Nov 21 1947 and that I last saw h[illegible] alive on Nov. 21 1947

Immediate cause of death	Duration
Toxemia	30 hrs
Due to Volvulus of	
Due to small intestine with intestinal	30 hrs
Other Conditions obstruction	

(Include pregnancy within three months of death)

Date of operation Nov 21 47

Major findings of operation: Volvulus of small intestine

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Paul Huggins Jr. M.D.

Address Johns Hopkins Hospital Date signed Nov 21, '47

Howard L. Dietrich M.D.

G57196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G57196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Box 175 Intercession City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geraldine Herndon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jesse

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-01

8. AGE: Years 46 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace W. Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Morrison
13. Birthplace ?

MOTHER
14. Maiden Name Mary Elizabeth Pauline
15. Birthplace ?

16 (c) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/41 (month) (day) (year)

(c) Cemetery or crematory Grandview Sandview West Va

18 (a) Funeral director Miller-Lahlberg

(b) Address 3714 Hanover St

19 (a) (Date rec'd by local registrar) (b) Huntington West Virginia

Nov 25 1941

correct age if especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1941, at 2 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1941, to Nov. 22 1941 and that I last saw her alive on Nov. 22 1941.

Immediate cause of death: Septicemia

Due to: subdural hematoma

Due to:

Other Conditions: non-specific pericarditis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy: subdural hematoma, pericarditis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Slaughter M. D.

Address Johns Hopkins Hosp. Date signed Nov 25 1941

X

657197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

657197
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5306 Purlington Way
(c) Hospital or institution: none 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5306 Purlington Way
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Ewing Brand

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Carl W. Brand
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1880

8. AGE: Years	Months	Days	If less than one day
67	5	12	hr. min.

9. Birthplace Glasgow, Scotland
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name James S. Ewing
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth Agnew
15. Birthplace Scotland

16 (a) Informant Ewing W. Brand
(b) Address 701 St. George's Road

17 (a) Burial (b) Date thereof 11/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~the crematory~~ Lakeview
Location Cleveland, Ohio

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 NOV 22 1947 (Huntington Williams, M.D.)
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1947, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Nov 23 1947, and that I last saw h[illegible] alive on 11-23 1947.

Immediate cause of death: Myocarditis
Due to: Arterio-sclerosis
Due to: Hypertension
Other Conditions:
(Include pregnancy within 3 months of death)

Duration
Fractional
"
"

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H N Moody M. D.
Address 1403 Park Ave. Date signed 11-25-47

correct age is especially important. Physicians: please write plainly.

VS 150

102 Churchwardo Road X

G57198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Kenway Drive
(c) Hospital or institution: none 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Kenway Drive (If rural give location)
(e) Citizen of foreign country NO (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Devries Ives

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife William M. Ives
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1872

8. AGE: Years 75 | Months 9 | Days - | If less than one day hr. min.

9. Birthplace Howard County, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Henry O. Devries
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Ann E. Shipley
15. Birthplace Howard Co., Md.

16 (a) Informant William M. Ives
(b) Address 1807 Kenway Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 23 1947 (Registrar) Huntington Williams M.D. (Registrar)

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1947 at 10.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1947 to Nov 22 1947 and that I last saw h.. alive on Nov 22 1947

Immediate cause of death: Myocardial Insufficiency — Duration: 2 days
Due to: Diabetes Telangiectasis — Duration: 10 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J Davis M. D.
Address 800 W. 33rd St. Date signed 11-24-47

VS 150

Dr. Davies X

G57199 BALTIMORE CITY HEALTH DEPARTMENT G57199
CERTIFICATE OF DEATH 477 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Ken Oak Road
(c) Hospital or institution: none 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Ken Oak Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Willian Tarun

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Flora Hoffman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 5, 1870

8. AGE: Years	Months	Days	If less than one day
77	3	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Atty.
11. Industry or business

FATHER
12. Name Willian Tarun
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant J. Turner Rux
(b) Address 551 Alson Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John L. Mitchell & Sons, Inc.
(b) Address 1908 Eutaw Place

19 (a) Date 1947 (b) Signature by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1947, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1947 to Nov 21 1947, and that I last saw h[illegible] alive on 11/20/ 1947.

Immediate cause of death Cancer of lung — Duration 6 Month
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry D. McCarty M. D.
Address 37 W. Preston St. Date signed 11-24-47

correct age is especially important. Physicians: please write plainly.

VS 150

Dr. Malone X

G57200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

G57200

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 Highwood Drive
(c) Hospital or institution: none 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Highwood Drive
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Albert B. Moore

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Maud Hutt Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1875

8. AGE: Years	Months	Days	If less than one day
72	3	16	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Nathaniel Moore
13. Birthplace Baltimore

MOTHER
14. Maiden Name Alice Hopkins
15. Birthplace Baltimore

16 (a) Informant Mrs. Maud H. Moore
(b) Address 613 Highwood Drive

17 (a) Burial (b) Date thereof 11/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~xxxxxxx~~ Greenmount
Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

NOV 23 1947 (b)
(Date rec'd by registrar)

correct age is especially important—registrar's responsibility

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24, 1943 to Nov. 19, 1947, and that I last saw him alive on Nov. 19 1947.

Immediate cause of death	Duration
Coronary occlusion	
a myocard. infarction	24 hrs.
Due to Arterio-sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William B. Stroman M. D.
Address 1041 St. Paul St. Date signed 10/2/47

Dr. Nathan Norman

G57201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G57201 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St. 17
(c) Hospital or institution: South Balto. Genrl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr Louis La Ricci

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-1946

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rosinata La Ricci
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10 1874

8. AGE: Years	Months	Days	If less than one day
73	0	11	hr. min.

9. Birthplace Italy
(Town, county and state)
10. Usual Occupation Retired
11. Industry or business Tailor

FATHER
12. Name Vincent La Ricci
13. Birthplace Italy

MOTHER
14. Maiden Name Clementina
15. Birthplace Italy

16 (a) Informant Wife-Mrs Louis La Ricci
(b) Address Above

17 (a) Burial (b) Date thereof Nov 24/1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mem Cathedral
Location Old Frederick Rd
18 (a) Funeral director Henry H Wight
(b) Address 901 Edmondson Ave
19 (a) (b)
Registrar

NOV 23 1947

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21 — 1947, at 6:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1947, to Nov 21, 1947 and that I last saw h alive on Nov 21, 1947.

	Duration
Immediate cause of death: Cardiac failure, acute	Immediate
Due to: Arteriosclerotic heart disease	Not Known
Due to:	
Other Conditions: Ca prostate	Not Known

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. D. Cooper M. D.
Address 58 E. Pt. Date signed 11/27/47

corresponding is especially important. Physicians, please

557202 B.C# A. 47925

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 557202 / 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore #5 Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2152 Wright Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Larry Reibl ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 42

8. AGE: Years	Months	Days	If less than one day
5	7	3	hr. min.

9. Birthplace Balt (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leonard Reibl
13. Birthplace Port Co Md

MOTHER
14. Maiden Name Dora F. Townsend
15. Birthplace Balt Md

16 (a) Informant Mrs Leonard Reibl
(b) Address 2152 Wright Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 26 47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Chapel
Location Forest Hall Md

18 (a) Funeral director Edgar L Lane
(b) Address Edmondson Village Md

19 (a) 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

Correct age is especially important if under 1 year

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22 1947, at 10:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1947 to 11-22 1947 and that I last saw h[illegible] alive on 11-22 1947.

Immediate cause of death cardio resp failure — Duration

Due to Acute Coronary Insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Rosen M. D.
Address Univ. Hosp. Balto, Md Date signed 11-22-47

X

G57203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G57203

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Queen Anne
(c) City or town Church Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Archie Fiddes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Julia Fiddes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Kent Co. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Wm. Fiddes
13. Birthplace Kent Co. Md

MOTHER
14. Maiden Name Penbrown
15. Birthplace "

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Church Hill
Location Church Hill

18 (a) Funeral director E. F. Lane
(b) Address Church Hill

19 (a) NOV 24 1947 (b) Huntington Mills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/47 19 , at 5.40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22/47 19 to 11/23/47, and that I last saw him alive on 11/23/47.

Immediate cause of death Mucous plug in Bronchus

Due to Loss of cough & dyspnea

Due to Cerebro-vascular accident (probably hemorrhage)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. B. Pinto, Jr. M.D.
Address University Hosp. Date signed 11/23/47 M. D.

correct age is especially important

57204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 57204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 936 Patapsco ave
(c) Hospital or institution: 25-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 936 Patapsco ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr Lena Sylvia C Sparck

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business Dentist

FATHER
12. Name Lipman Silverman
13. Birthplace Russia

MOTHER
14. Maiden Name Zelda R Waranch
15. Birthplace Russia

16 (a) Informant Abraham L. Waranch
(b) Address 736 Resivor St

17 (a) Burial (b) Date thereof Nov 24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Auburn Foundation
Location 3600 E Baltimore

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) NOV 24 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION 10.30

20. DATE OF DEATH November 22 1947, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1947 to Nov. 22 1947 and that I last saw h[illegible] alive on Nov. 22 1947.

Immediate cause of death coronary thrombosis attack — 4 days
Due to Sclerosis of the coronary
Due to high blood pressure
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Neuhauser M. D.
Address 936 Patapsco Ave Date signed Nov 23/47

V S 150

57205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G57205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Broadway
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Lovett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	WHITE	widowed

6 (b) Name of husband or wife Kate Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
88			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Gordon Lovett
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Harry Lovett
(b) Address 1950 W. Franklin St.

17 (a) Burial (b) Date thereof 11 24 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Har Zion Cong
Location Boundary Lane

18 (a) Funeral director Sol Luiner & Bro
(b) Address 1124-26 W. North Ave.

19 (a) NOV 24 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

correct age if apparently improbable

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Nov 1947 19 , at 12:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11/47 19 , to 11/24/47 19 , and that I last saw him alive on 11/24/47 19 .

Immediate cause of death	Duration
Cardiac Failure	Terminal
Due to Intestinal Obstruction	
Due to Sigmoidal mass	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/11/47

Major findings of operation: Perforated urethra.

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Asher Hollander M. D.
Address Sinai Date signed 11/24/47

X

657206

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46E

Registered No. 657206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital or~~ institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) ~~City or~~ town Upper Falls
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward V. Standiford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Belle Standiford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5th 1859

8. AGE: Years	Months	Days	If less than one day
88	9	16	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Journeyman
11. Industry or business Carpentering

FATHER
12. Name Charles Standiford
13. Birthplace Md.

MOTHER
14. Maiden Name Pamelia Evans
15. Birthplace Md.

16 (a) Informant Mrs. William Bell
(b) Address Upper Falls Md.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Salem M.E. Church
Location Upper Falls

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St. Baltimore, Md.

19 (a) NOV 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to Nov 25 1947, and that I last saw him alive on Nov. 19 1947.

Immediate cause of death	Duration
GENERALIZED CARCINOMATOSIS	2 months
Due to CARCINOMA - CAECUM	1yr (?)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman R. Kerman M.D.
Address 3803 Edmondson Ave Date signed 11/22/47

Correct age is supremely important. Please verify.

VS 150

57207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G57207

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Universities Hospital 20-1
(d) Length of stay in hospital or inst. (yrs. (mos.) or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1837 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA FLOREY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Louis J. Florey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1904

8. AGE: Years 43 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER 12. Name William Kessler

13. Birthplace Md.

MOTHER 14. Maiden Name Alberta Castle

15. Birthplace Md

16 (a) Informant Louis J. Florey

(b) Address 1837 W. Franklin St.

17 (a) Burial (b) Date thereof 11/26/47 (Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Western

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St.

19 (a) NOV 24 1947 (Date Rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22 1947, at 6 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1947, to 11-22 1947, and that I last saw h~~im~~er alive on 11-22 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma of cervix — grade IV	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Winfred Gelsenheimer M. D.
Address Universities Hosp Date signed 11-22-47

Correct age if especially important — registrar to verify

VS 150

X

G57208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13c

Registered No. G57208

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Maryland Ave
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) /
If yes, name country

3 (a) FULL NAME Louis C Quantmeyer

3 (b) If veteran, name war W.W. #1

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of ~~husband or~~ wife Lena Quantmeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10th 1895

8. AGE: Years 52 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Crown Cork & Seal Co.

FATHER 12. Name Henry Quantmeyer

13. Birthplace Md.

MOTHER 14. Maiden Name Katherine Kroomer

15. Birthplace Md

16 (a) Informant Mrs. Lena Quantmeyer

(b) Address 2650 Robb st.

17 (a) Burial (b) Date thereof 11/26/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory U. S. National

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul st.

19 (a) NOV 24 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

Correct age in especially important cases.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1947, at 3:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10, 1947 to Nov 23 1947, and that I last saw him alive on Nov 23 1947.

Immediate cause of death (a) Lobar Pneumonia — Duration 3 days

Due to Infection

Due to

Other Conditions Intercurrent
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Snyder M. D.

Address 100 St Paul St Date signed Nov 23 47

X

57209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B

Registered No. G57209

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Lombard St
(c) Hospital or institution:
Univ. Hosp. 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 652 Portland st
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W Sadler

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-0558

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lulu Sadler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~11~~ 1/3/1902

8. AGE: Years	Months	Days	If less than one day
45	10	20	hr. min.

9. Birthplace Salt Lake City - Utah
(Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business Md. Drydock

FATHER
12. Name Harry M. Sadler
13. Birthplace Utah

MOTHER
14. Maiden Name Eliza Routh
15. Birthplace Germany

16 (a) Informant Miss Ruth Sadler
(b) Address 652 Portland St.

17 (a) Burial (b) Date thereof 11/26/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 24 1947 (b) Huntington W. Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1947 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1947 to 11/23 1947 and that I last saw h[illegible] alive on 11/23 1947.

Immediate cause of death Cardiac decompensation — Duration

Due to Intestinal obstruction

Due to [illegible]

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E. Hall M. D.

Address Date signed

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57210 CH. 114967 136 Registered No. 57210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Bethel Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie, Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Edward (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14- 1882 ?

8. AGE: Years	Months	Days	If less than one day
65 ?	-	5	hr. min.

9. Birthplace VA.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Squire Johnson
13. Birthplace VA.

MOTHER
14. Maiden Name Sophia Claybourne
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Nov. 25 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Baltimore, Md

18 (a) Funeral director Geo. O. Wilson
(b) Address 1000 Brantly Ave

19 (a) NOV 24 1947 at Huntington, W. Va.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 - 1947, at 7.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11- 3 - 1947 to 11 - 19- 1947, and that I last saw her alive on Nov. 19 -1947

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. P. Scarborough M. D.
Address Balto. City Hosp. Date signed 11-24-47

V S 150

57211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G57211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20D
(e) Length of stay in Baltimore (yrs., mos., or days) all

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Wester Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** John H. THOMAS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name John Thomas
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rose, allen
15. Birthplace Cambridge md

16 (a) Informant Charles E. Thomas
(b) Address 611 N. Chapel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Baseley ave

19 NOV 24 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16/47 19 at 10:30 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Sears M.D. Medical Examiner.
Date signed 11/17/47

VS 191

7212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 82a

G57212
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 4-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 W. Lafayette St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME George Mornevgater

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8/29/1

8. AGE: Years 57 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 13 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 NOV 24 1947 Huntington Williams M.D.
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12th 1947, at 8:25 a. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Edema

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Carl L. Rugh M.D.
Medical Examiner.
Date signed 11/13/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G57213

57213 44223 131 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 152
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1545 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Foy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6/15

8. AGE: Years	Months	Days	If less than one day
32	2	8	hr. min.

9. Birthplace Fla (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name David Foy
13. Birthplace Fla.

MOTHER
14. Maiden Name Victoria Staten
15. Birthplace Fla

16 (a) Informant Roy E. Chambers
(b) Address 1406 Harford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director W. Galetas
(b) Address 918 Druid Hill ave

19 (a) NOV 24 1947 (Date rec'd by registrar) (b) Huntington, Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1947, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1947, to 11/14 1947, and that I last saw alive on 11/14 1947.

Immediate cause of death	Duration
Uremia	2 1 hrs
Due to Chronic glomerulonephritis	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 15 Nov 47

COPIES NOT IS especially important

VS 150

X

57214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. 57214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-1
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 900 Chauncey Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses A. Cummins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation merchant

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Ida Cummins
(b) Address 900 Chauncey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-47 (month) (day) (year)
(c) Cemetery or crematory B'Nai Israel
Location Baltimore Ave

18 (a) Funeral director Joel Lewis, Inc
(b) Address 2100 Eutaw Place Huntington Woodmere, Md

19 (a) NOV 24 1947 (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1947, at 2:00 P.M.

21. I certify that I took charge of the remains described above, held an Aug Ed Dup Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Reich M.D. Medical Examiner.
Date signed Nov 23, 1947

57215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57215

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 134 S. Potomac Street
(c) Hospital or institution: 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 134 S. Potomac Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA MITCHELL

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Edmond C. Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 8, 1876

8. AGE: Years 71 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Henry Husted
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna E. Knoble
15. Birthplace: Germany

16 (a) Informant: Mr. Milton H. Mitchell
(b) Address: 3111 Shannon Drive - 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 NOV 24 1947 (Date Rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH November 21 1947, at 5.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Nov. 21 1947 and that I last saw HER alive on Nov. 20 1947.

Immediate cause of death: Cardiac dilatation — Duration:
Due to: Chronic myocarditis
Due to: Coronary heart dis.
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Charles L. MacMenamin M. D.
Address: 2911 E. Baltimore St Date signed: Nov. 24 1947

VS 150

X

657216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 657216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 N Lugerne Ave
(c) Hospital or institution: 8-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 N. Lugerne Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Risby Lumsden Jr.

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 215-09-1922
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Catherine Miles Lumsden
6 (c) If alive, give age 44 years
7. Birth date of deceased (mo., day, yr.) April-15-1895
8. AGE: Years 52 | Months 7 | Days 7 | If less than one day hr. min.
9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Pipe Fitter
11. Industry or business U.S. Coast Guard

FATHER
12. Name John Lumsden
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Barbara Pendlebaum
15. Birthplace Balto. Md.

16 (a) Informant Catherine Miles Lumsden
(b) Address 1431 N. Lugerne Ave.
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-25-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Wilkens Ave
18 (a) Funeral director John C. Melly Son
(b) Address 2432 E. Oliver St
NOV 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-1947, at 6.45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 - 1947, to Nov 22 - 1947, and that I last saw h[im] alive on Nov 19 - 1947.

Immediate cause of death: Coronary Thrombosis — Duration: a few minutes
Due to
Due to
Other Conditions: Sprained back — 13 da.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Chester Riland M. D.
Address 2532 Edmondson Ave Date signed 11-22-47

Correct age is especially important. Please answer all questions.

VS 150

57217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 057217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 N. Streeper St
(c) Hospital or institution: 61

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Streeper St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Kaiser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1871

8. AGE: Years	Months	Days	If less than one day
76	8	-	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Nicholaus Kaiser
13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Kleinschmidt
15. Birthplace Germany

16 (a) Informant Herman E. Kaufmann
(b) Address 117 N. Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-37 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location O'Donnell St & Kelly Ave

18 (a) Funeral director Kelly Bros
(b) Address 2405 E. O'Donnell St

19 (a) NOV 24 1937 (Date received by local registrar) (b) Huntingtown Williamsburg Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 20 - 1937, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1937 to Nov 20 1937
and that I last saw h alive on Nov 20 1937

Immediate cause of death Apoplexy

Duration
3 days

Due to Cardiac Insufficiency

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred Ruzicka MD
Address 5100 Baltimore Nov 24 1937 Date signed

F.F. RUZICKA, MD

57218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V-937

052218 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 128 S Broadway
(c) Hospital or institution: L-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 128 S Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Mc=Carthy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, ~~married~~, widowed, or divorced: Widow

6 (b) Name of ~~husband~~ or wife: of Daniel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3 1867

8. AGE: Years 80 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ?

FATHER 12. Name ? Shapelton

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name ? Closey

15 Birthplace Baltimore Md

16 (a) Informant Katherine Bere

(b) Address 128 S Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Darford Road

18 (a) Funeral director John G Moran

(b) Address 3600 E Baltimore St

NOV 24 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1947, at 9 A.M. ~~P.M.~~ #5

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Nov 22 1947, and that I last saw ~~her~~ alive on Nov 23 1947.

Immediate cause of death: General Atherosclerosis — Duration 5 yrs

Due to: Chronic Myocarditis — Duration 5 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, industrial place)
(e) Means of injury:

23. Signature Milton L. Solomon M.D.

Address 129 S. Broadway Date signed 11/22/47

VS 150

G57219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1218

Registered No. G57219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 63 W. West St
(b) Street address 63 W. Balto. West St
(c) Hospital or institution: ✓ 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7mos
(e) Length of stay in Baltimore (yrs., mos., or days) 77 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 63 W. West St (If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country ✓

3 (a) FULL NAME Eugina Brown

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alfred Brown
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) 12 20 1865

8. AGE: Years 82 | Months 10 | Days 24 | If less than one day: hr. ✓ min.

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation Housework

11. Industry or business House work

FATHER
12. Name Unknown
13. Birthplace ✓

MOTHER
14. Maiden Name Mary Adams
15. Birthplace Virginia

16 (a) Informant Elizabeth Holmes
(b) Address 63 W. West

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 11 24 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Balto.

18 (a) Funeral director Walter B. Spriggs
(b) Address 139 W. Hamburg St.

Date received ..... Registrar Washington Williams

VS 180

correct age is especially important—registrars must

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1947, at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1947, to Nov 21 1947, and that I last saw h.. alive on Nov 21 1947.

Immediate cause of death Pneumonia — Duration 5 days
Due to Age
Due to .....
Other Conditions Nephritis
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Wm. James C Cooper M. D.
Address 1016 E. Monument St Date signed 11-21-47

657220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

657220 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 28-2
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 17
(e) Length of stay in Baltimore (~~yrs., mos., or days~~) 68

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Maine Ave.
(If rural give location)
(e) Citizen of foreign country? (~~Yes or No~~)
If yes, name country

3 (a) FULL NAME Frank Herbert Knipp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, ~~married, widowed, or divorced~~

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1879

8. AGE: Years 68 | Months 8 | Days 16 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Manufacturer

11. Industry or business Partner John C. Knipp & Son

FATHER
12. Name John C. Knipp
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Julia C. Grasley
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Howard F. Knipp
(b) Address 204 Goodwood Gardens

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 NOV 24 1947 (Date received by Registrar) Washington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1947, at 3:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1947, to Nov. 21 1947, and that I last saw him alive on Nov. 21 1947.

Immediate cause of death	Duration
Congestive Cardiac failure	
Due to Myocardial Infarct	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel A Knipp
Address Union Memorial Hosp. Date signed 11/21/47

VS 150

correct age is especially important. Physicians: please w

657221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. 657221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 Briarwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry ~~Britton~~ Brittain

3 (b) If veteran, name war: WW II
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: Elizabeth Britt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25. 1901

8. AGE: Years 46 | Months 2 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Novelty Store

FATHER
12. Name Samuel L Brittain
13. Birthplace Pa

MOTHER
14. Maiden Name Ida L Leuck
15. Birthplace Md

16 (a) Informant Elizabeth Brittain
(b) Address 15 Briarwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day), (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Md.

18 (a) Funeral director Edw S Mar Hall
(b) Address Catonsville Md

19 (a) NOV 24 1947 (Date received by registrar) Curtis G Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22/47 19 10:P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 11/23/47

7222 BC# 4 98765 BALTIMORE CITY HEALTH DEPARTMENT / X

CERTIFICATE OF DEATH / 159

Registered No. 7222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W
(c) Hospital or institution: Women Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County — Carroll
(c) City or town Baltimo Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. — 29 Main St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME Baby Boy Hartz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11/19/47

8. AGE: Years — | Months — | Days — | If less than one day — hr. 5 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name Leonard Hartz
13. Birthplace Baltimo

MOTHER — 14. Maiden Name Thelma Ruth Barnhart
15. Birthplace Baltimo, Md.

16 (a) Informant mother
(b) Address —

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Hart Burial

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) NOV 24 1947 (b) Registrar Huntington Williams, M.D.

correct age is especially important. Physicians, please w

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1947, at 4 42 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9/47 19 to 11/19/47 19, and that I last saw him alive on 11/19/1947

Immediate cause of death Prematurity

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. L. Dennis M.D.
Address Women Hospital Date signed 11/19/47

VS 150

X

57223 B.C. 94539 JL - 115341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G57223 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 N. Chester st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Winters - Evelyn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1947

8. AGE: Years	Months	Days	If less than one day
			11 hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl A. Winters
13. Birthplace Pa.

MOTHER
14. Maiden Name Evelyn Stellings
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof 9:00 AM 11-21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cremation
Location Baltimore City Hosp.

18 (a) Funeral director
(b) Address 4940 Eastern Ave.

19 (a) NOV 24 1947
(Date received by registrar) Huntington Williams, M.D.

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1947, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1947 to Nov. 19 1947, and that I last saw him alive on Nov. 19 1947

Immediate cause of death: Fetal Atelectasis — Duration: At birth

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold H Becker M.D.
Address Balto City Hosp. Date signed 11/24/47

57221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

57224

Registered No. 24747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1131 No. Carey St.
(c) Hospital or institution: 16-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 No. Carey St. (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Henry Parker

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	M

6 (b) Name of husband or wife Mary Lola
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1896

8. AGE: Years	Months	Days	If less than one day: hr.	min.
51	3	17		

9. Birthplace West River A.A.Co. Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Caroline Burgess
15. Birthplace Anne Arundle Co.

16 (a) Informant Mrs. Thomas H. Parker
(b) Address 1131 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director George G. Gilson
(b) Address 1303 Pennsylvania Ave

19 NOV 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1947 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Nov. 22 1947, and that I last saw him alive on Nov. 22 1947.

Immediate cause of death Coronary Thrombosis — Duration 4 yrs.
Interval - volunteer heart disease.
Due to Hypertensive - Cardio Vascular disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ronald Blighton M.D.
Address 2129 Druid Hill Ave. Date signed 11/23/47

correct age is especially important. Typewrite or print plainly in ink.

VS 150

X

17225 B.C 4-8616-B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 657225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928- S. Dean St.
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 S.Dean St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARDELLA SHEARRILL I

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 1947

8. AGE: Years	Months	Days	If less than one day
	3	29	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George H. Shearrill
13. Birthplace Baltimore City

MOTHER 14. Maiden Name Genevieve Smith
15. Birthplace Woodstock Va

16 (a) Informant George H. Shearrill
(b) Address 928 S. Dean St

17 (a) Burial (b) Date thereof Nov. 24-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1615 McElderry St

19 NOV 24 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1947, at 9.10 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to aspiration of vomitus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 26/9
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury

23. Signature Earl L. Kaylor M.D.
Medical Examiner.
Date signed 11-21-47

S.C. # 9-55281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. C57226

C57226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 Baker Street
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) XXXXX
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Baker Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME VIVIAN APPLETON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1946

8. AGE: Years 1 | Months 3 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elijah Appleton
13. Birthplace S.C.

MOTHER
14. Maiden Name Isabell Hamilton
15. Birthplace St Mary's Co., Md.

16 (a) Informant Elijah Appleton
(b) Address 618 Baker Street

17 (a) Burial (b) Date thereof 11/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

19. (a) Filed 1947 (b) Registered by registrar Washington Williams, M.D.

Correct age is especially important. Please give it.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1947, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1947, to Nov 23 1947 and that I last saw h[illegible] alive on Nov 23 1947.

Immediate cause of death: Respiratory failure — Duration
Due to: Bronchus pneumonia left
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1223 Druid Hill Ave Date signed

VS 150

X 11-24-47

G57227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G57227
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd.
(c) Hospital or institution: Colonial Nursing Home 28-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Sorrento Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Albertina S. Cleary

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~wife~~ late John E. Cleary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14 1873

8. AGE: Years	Months	Days	If less than one day
74	2	7	hr. min.

9. Birthplace Brooklin N.Y.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Franklin Stebbins
13. Birthplace Brooklin N.Y.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Brooklin N.Y.

16 (a) Informant Mr. Jerome F. Barnard
(b) Address 14 First N.W. Washington D.C.

17 (a) Burial (b) Date thereof Nov. 26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~xxxxxx~~ Greenwood
Location Brooklin N.Y.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

NOV 24 1947 (b) Huntington Williams M.D.
(Date received by registrar)

cannot age is especially important. registrar's number.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1947, at 9:22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to 11-21 1947, and that I last saw h~~e~~r alive on 11-20 1947.

Immediate cause of death	Duration
Coronary Thrombosis	Instantaneous
Due to Auricular Fibrillation	unknown
Due to Generalized Arteriosclerosis	1 yr
Due to Senile Dementia	1 yr?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William L. Deaver M. D.
Address 3025 Belair Rd Date signed 11-22-47

X

G57228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57228
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.U.H.
(b) Street address
(c) Hospital or institution: University Hospital 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1073 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1903

8. AGE: Years	Months	Days	If less than one day
44	8	22	hr. min.

9. Birthplace Portsmouth Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Daniel Smith
13. Birthplace Va

MOTHER
14. Maiden Name Florence Smith
15. Birthplace Va

16 (a) Informant Mildred Dixon
(b) Address 1073 W. Lexington St.

17 (a) Burial (b) Date thereof 11-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Alburn Cemetery
Location Md.

18 (a) Funeral director Wm. A. Jackson
(b) Address 916 Penna. Ave.

NOV 24 1947
(Date rec'd by registrar)

(b) Huntington Williams, M.D.
Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1947, at 1:35 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Sabinski M.D.
Medical Examiner.
Date signed 11/22/47

G57229 B.C # 4-74778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57229 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Patapsco Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Park Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DIANA SPENCER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May. 30 - 47

8. AGE: Years | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name James Scott
13. Birthplace Md.

MOTHER
14. Maiden Name Ethel Spencer
15. Birthplace Md.

16 (a) Informant Ethel Spencer
(b) Address 17 Park Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Md.

18 (a) Funeral director Wm. B. Jackson
(b) Address 916 Penna. Ave.

19 (a) NOV 24 1947 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1947, at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxia due to aspiration of vomitus

Due to

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: D.O.A. Hosp.

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 11-21-47

657230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

657230 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 9-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 43

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 McKewin (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George R. Durand

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Irene Durand
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 7-10-99

8. AGE: Years	Months	Days	If less than one day
43	4	12	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Packing

FATHER
12. Name John G. Durand
13. Birthplace Balto

MOTHER
14. Maiden Name Elizabeth Aegier
15. Birthplace Balto

16 (a) Informant Wife
(b) Address Same

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Harry H. Wirtz
(b) Address 4601 Edmondson Ave

19 (Date received) 1947 (Registrar's signature) Christopher Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22 1947, at 9 29/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1947 to 11-22 1947, and that I last saw h[illegible] alive on 11-22 1947

Immediate cause of death	Duration
Cerebral Embolism	3 hrs
Due to Arteriosclerosis Heart Disease	2 years
Due to and Complicating Senile Cerebral Sclerosis	2 years
Other Conditions Cardiac	2 months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Arteriosclerosis Heart
of autopsy: Confirmation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Gott M. D.
Address Mercy Date signed 11-23-47

correct age is especially important. Physicians, please

150

G57231 BALTIMORE CITY HEALTH DEPARTMENT G57231 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp. 28th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days) 3 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Emil Herman Aged Home
22 S. Athol Ave (If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Herman Emil Barkowsky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Millie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			....hr. ....min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business

FATHER
12. Name Heinlold
13. Birthplace germany

MOTHER
14. Maiden Name Amalie Krohnert
15. Birthplace germany

16 (a) Informant Emil Herman Home
(b) Address 22 S. Athol Ave

17 (a) To Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director Harry H Wittstadt
(b) Address 4101 Edmondson Ave

19 (a) ..... (Registrar) (b) .....

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1947, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1947 to 11-23 1947, and that I last saw him alive on 11-23 1947.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature C B Bearse M. D.
Address Univ. Hosp. Date signed 11-25-47

X

G57232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57232 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Christian St.
(c) Hospital or institution: 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Christian St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles R. Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Dorothy Cissel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 31, 1908

8. AGE: Years	Months	Days	If less than one day
39	9	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and State)

10. Usual Occupation Highway foreman

11. Industry or business City of Balto

FATHER 12. Name Clarence Taylor

13. Birthplace Maryland

MOTHER 14. Maiden Name Ella B. Addison

15. Birthplace Maryland

16 (a) Informant Mrs. Dorothy Taylor

(b) Address 2007 Christian St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto. Md.

18 (a) Funeral director Harry H. Wilhelm

(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b)

VS. 12 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1947, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1946 to Nov 21 1947 and that I last saw h[illegible] alive on Nov 21 1947

Immediate cause of death Coronary Thrombosis — Duration

Due to — —

Due to — —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred Cole M. D.

Address 1934 Watkins Ave. Date signed 11-21-47

X

B.C.-T-51807

G57233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G57233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 233
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 Light Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emil Samuel Warner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1942

8. AGE: Years	Months	Days	If less than one day
5	3	14	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Warner.
13. Birthplace Phila. Pa.

MOTHER
14. Maiden Name Kathleen Lutey
15. Birthplace U.S.

16 (a) Informant Family
(b) Address 1938 Light St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 11-24-47 (month) (day) (year)
(c) Cemetery or crematory G/W Haven
Location G/W Boyce

18 (a) Funeral director Joseph L. McCauley
(b) Address 1891 E. Fort Ave.

19 (a) 24 1947 (b) Huntington Williams M.D. Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1947, at 1.25 p. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Ruptured Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 24/d

(a) Date of injury 11-21-47 1 P. M.
(b) Where did injury occur? 1901 Light St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by auto

23. Signature Earl L. Ryan M.D. (Medical Examiner)
Date signed 11-21-47

G57234 — BALTIMORE CITY HEALTH DEPARTMENT — G57234 Registered No.

CERTIFICATE OF DEATH 1/21 B

PLACE OF DEATH:
Baltimore City, Maryland
Street address 1706 W Lanvale St
Hospital or institution: 16-3
Length of stay in hospital or inst. (yrs., mos., or days)
Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 W. Lanvale St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

(a) FULL NAME Alice Campbell.
(b) If veteran, name war
3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

(b) Name of husband or wife: William Thomas Campbell.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/10/82

AGE: Years	Months	Days	If less than one day
65	3	12	hr. min.

8. Birthplace Virginia. (Town, county, and state)
9. Usual Occupation Domestic.
11. Industry or business Housework.
12. Name Not Known
13. Birthplace
14. Maiden Name Not Known
15. Birthplace
16 (a) Informant William Henry Campbell
(b) Address 1706 W Lanvale St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Park
Location Balto Co
18 (a) Funeral director Mr. Geo. T. A. Gibson
(b) Address 1735 Druid Hill Ave.
NOV 24 1947 (Date rec'd by registrar) (b)
Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1947, at 4 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 11/14/47 to 11/22/47 and that I last saw h[illegible] alive on 11/22/47

Immediate cause of death	Duration
(a) Acute Myocarditis	5 days
Due to (b) Chronic Arteritis	3 mo.
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. T. Gunn M. D.
Address 502 N. Carlington [illegible] 11/24/47

57235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No. 57235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1738- E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLIFTON ROSS READ

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary Anna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 2, 1899
8. AGE: Years 48 | Months 4 | Days 20 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Grand Union Tea co.
11. Industry or business Salesman

FATHER
12. Name James Read
13. Birthplace Md.

MOTHER
14. Maiden Name Mollie Dodd
15. Birthplace Md.

16 (a) Informant Mrs. Mary Anna Read
(b) Address 3303 Lerch Drive, 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road. 14

19 (a) NOV 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1947, at 6.20 A.M.

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-18-47 at about 3 p. M.
(b) Where did injury occur? 1738 E. Lanvale St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating gas

23. Signature Carl H. Kruger M.D. (Medical Examiner)
Date signed 11-22-47

X

57236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57236

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 12-11 Light St

(c) Hospital or institution: South Balto Gen. Hosp 9-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 14 (If outside city or town limits, write RURAL and give town)

(d) Street No. 4200 Elsrode Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wilbur L. Wicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Ethel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1894

8. AGE: Years 53 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Hospital orderly

11. Industry or business St. Joseph's Hospital

FATHER 12. Name Wilbur L. Wicks

13. Birthplace Md.

MOTHER 14. Maiden Name Fannie Reilly

15. Birthplace D. C.

16 (a) Informant Mrs. Lutz (Vernon E.)

(b) Address 4200 Elsrode Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto

18 (a) Funeral director L. J. Luck Stafford

(b) Address 5305

19 (a) NOV 24 1947 (Date rec'd by registrar) (b) Signature of registrar Williams Smith Balto Gen

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1947, at 4:25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 18 1947, to Nov 23 1947, and that I last saw him alive on Nov 23 1947

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Cerebral arteriosclerosis	
Due to Hypertensive cardio-vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harold Dillon Date signed M/D 11/23/47

correct age is especially important. Physicians, please

VS 150

7237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85

Registered No. G57237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts.
(c) Hospital or institution: University 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 E. 20th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred A. Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Thomas A.
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) June 22-1921

8. AGE: Years	Months	Days	If less than one day
26	5	1	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Howard Conley
13. Birthplace W Va.

MOTHER
14. Maiden Name Anna
15. Birthplace W. Va.

16 (a) Informant Mrs. Joseph Stanley
(b) Address 144 E Stevenson St.

17 (a) Burial (b) Date thereof 11-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto

18 (a) Funeral director L. J. Cook
(b) Address 5305 Old Frederick Rd.

19 (a) NOV 24 1947 (b) Hamilton, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1947 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1947 to 11/23 1947 and that I last saw h[illegible] alive on 11/23 1947.

Immediate cause of death	Duration
Respiratory collapse	
Due to Status epilepticus	
Due to Idiopathic epilepsy	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible], M. D.
Address [illegible] Date signed 11/23/47

Correct age is especially important if deceased was under one year.

VS 150

G57238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No. G57238

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5451 Belair Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME George J. Naylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married), widowed, or divorced.
M	W	Margaret

6 (b) Name of husband or wife [redacted]

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) May 3 1899

8. AGE: Years	Months	Days	If less than one day
48	6	18	hr. min.

9. Birthplace Balto - Md
(Town, county, and state)

10. Usual Occupation Gen'l Electric Co.

11. Industry or business Manufacturing

FATHER
12. Name William Naylor
13. Birthplace Md.

MOTHER
14. Maiden Name Florence Holman
15. Birthplace Md.

16 (a) Informant Mrs. Margaret Naylor
(b) Address Same 5451 Belair Rd

17 (a) Burial (b) Date thereof 11-25-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director J. J. Ruck
(b) Address 5805 Harford Rd-14-

19 (a) NOV 24 1947 Baltimore, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21 1947 at 11 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1947 to 10-21 1947 and that I last saw h[illegible] alive on 10-21 1947

Immediate cause of death	Duration
a. Uremia Systemic Glomerulo Nephritis	
Due to b. Essential Hypertension	20 yrs
Due to c. Septicaemia	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: Gross and Microscopic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William G. Bost M. D.
Address Mercy Date signed 11-21

correct age is especially important. Physicians: please write

VS 150

57239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46H

Register No. 057239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital 7 N 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Hamilton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lilly Peirce (Lillian Pearce)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Wh

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20-1883

8. AGE: Years 64 | Months 0 | Days 1 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Henry Frick
13. Birthplace Germany

MOTHER
14. Maiden Name Catharine ~ J
15. Birthplace

16 (a) Informant Mrs. John J. Pearce
(b) Address 2815 Hamilton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/47 (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 NOV 24 1947 (Date rec'd by registrar) (By) Municipal Registrar

Correct age is especially important if under 1 year or over 65

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1947, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Nov 4 1947, and that I last saw her alive on Nov. 19 1947.

	Duration
Immediate cause of death: Cerebral metastasis	
Due to: Peritoneal Carcinomatosis	
Due to	
Other Conditions: Incisional hernia post op. (Include pregnancy within 3 months of death)	

Date of operation: N.C.P.
Major findings of operation: Incisional hernia, peritoneal carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wolfgang Jr. M.D.
Address Redwood & Greene Date signed 11/24/47

VS 150

X

G57240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G57240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 253 S. Washington St
(c) Hospital or institution: 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 76

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 253 S. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Wittmar Thomas

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Herman Thomas
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 25 - 1852
8. AGE: Years 95 | Months - | Days 28 | If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business at home

FATHER
12. Name John F. Wittmar
13. Birthplace Germany

MOTHER
14. Maiden Name Leticia Dietle
15. Birthplace Germany

16 (a) Informant George Heller
(b) Address 1933 Gough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25 (month) (day) (year)
(c) Cemetery or crematory Emmanuel Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 Orleans St

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

NOV 24 1947

VS 150

Correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22nd 1947, at 1 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1947 to Nov 22 1947. and that I last saw her alive on Nov 21 1947.

Immediate cause of death: Hypostatic Pneumonia
Chronic Nephritis
Due to: General senile changes
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 4 days, 8d +

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Geo. D. Lofstrom M. D.
Address 431 N. Patterson Park Ave Signed 11/27/47

X

57241 GM. 16265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 22 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvester, Whitfield

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Sylvester Whitfield
13. Birthplace MD.

MOTHER
14. Maiden Name Mary Grauling
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Nov 24 -
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2015 Bloom St

19 (a) Nov 24 1947 (b) Huntington, West Virginia
(Signature of undertaker or relative)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 - 1947, at 5.34P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 - 1925 to 11- 21 - 1947, and that I last saw him alive on Nov. 21 - 1947.

Immediate cause of death	Duration
Coronary Thrombosis	10 min.
Due to Arteriosclerotic heart disease	unknown
Due to	
Other Conditions Congenital Dilatation Atelectasis (Bodies Disease	life

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Julius Stolz, Jr. M.D.
Address Balto. City Hosp. Date signed 11/21/47

V S 150

G57242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave
(c) Hospital or institution: Pine Ridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 N Castle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A Neyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Nicholas G Neyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20 1873

8. AGE: Years 74 | Months 8 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Ludwig Lepper

13. Birthplace Ger

MOTHER 14. Maiden Name Dont Known

15. Birthplace

16 (a) Informant Charles Neyer
(b) Address 1014 N Castle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26/47 (month) (day) (year)

(c) Cemetery or crematory Balto Cem
Location Balto

18 (a) Funeral director Wilmhelm Funeral Home
(b) [redacted] Col & Orleans St

19 (a) ____ (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1947, at 7 10 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 1947 to Nov 21 1947, and that I last saw h[illegible] alive on 11 20 47

Immediate cause of death Hypertension — Duration 2 yrs
Due to Cardiac Insufficiency
Due to Renal Failure
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation?
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Reynolds M.D.
Address 1000 N Calvert St Date signed 11-22-47

VS 150

657243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 657243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 N Milton
(c) Hospital or institution: 8.3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 N Milton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flora Holter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Louis Holter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17 - 1875

8. AGE: Years 72 | Months 3 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Wesley Horseman
13. Birthplace Balto

MOTHER
14. Maiden Name Dont Know
15. Birthplace Md

16 (a) Informant Louis Holter
(b) Address 1221 N Milton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Catonsville

18 (a) Funeral director Ulbrich Funeral Home
(b) Address 2008 Orleans St

19 (a) NOV 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1947, at 8:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1947, to Nov 22 1947, and that I last saw her alive on Nov 20 1947.

Immediate cause of death	Duration
Coronary Thrombosis (Ist)	11-22-47
Cardio-Vascular-Renal-Dis	—
Due to arterio-Sclerosis	
Due to	
Other Conditions Arterial Hypertension	
Obesity	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Louis T. Strumsen M. D.
Address 722 N. Kenwood Ave Date signed 11/27/47

X

57244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 057244

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1434 Patapsco St.
(c) Hospital or institution: 23-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 Patapsco St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Helen M. Slemaker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife George A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13-1891

8. AGE: Years	Months	Days	If less than one day
56	3	7	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business House wife

FATHER 12. Name John B. Shultz

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Maggie M. Cann

15. Birthplace Baltimore Md

16 (a) Informant George A. Slemaker

(b) Address 1434 Patapsco St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/1947 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 1426 Light St.

19 NOV 24 1947 (b) Date rec'd by registrar [illegible] Williams, M.D.

VS 150

correct age if only month supplied

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1947, to Nov 21 1947, and that I last saw NV alive on 11/21 1947

Immediate cause of death Acute Cardiac failure — Duration

Due to C. A. Arteriosclerosis

Due to Ch. Myocardial disease

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.

Address 733 Augusta Dr. Date signed 11/24/47

X

57245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G57245 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-1
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1176 Ridgely St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Leimbach

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife George Leimbach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-1-79

8. AGE: Years 68 | Months 3 | Days 22. | If less than one day hr. min. 1679

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Show.
11. Industry or business

FATHER
12. Name John N. Weigma
13. Birthplace Md.

MOTHER
14. Maiden Name Babana Koons
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Balto Cem (Burial, cremation, or removal) (b) Date thereof 11-23-47 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location E. Fourth Ave

18 (a) Funeral director Edward Foulkrod
(b) Address 2259 Walbrook

19 (a) (Date rec'd by reg.) (b) Huntington Williams M.D. Registrar

NOV 24 1947

Corrected due to inadvertent omission of important information

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 19 47 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1947 to Nov. 23 1947 and that I last saw him alive on Nov. 23 19 47

Immediate cause of death ? coronary occlusion, ? pulmonary embolus

Due to A S H D, deep vein thrombosis

Due to

Other Conditions Diabetes mellitus, arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur A. Siebens M. D.
Address Johns Hopkins Hosp. Date signed 11/23/47

92D

57246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G57246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution:
West Balto. General Hospital 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3315 Brighton St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER PENN GAREIS

3 (b) If veteran, name war: W.W. 1
3 (c) Social Security Account No. 215-01-3593

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Inez Gareis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1895

8. AGE: Years 52 | Months 8 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Charles A. Gareis
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma A. Bartlett
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Inez Gareis
(b) Address 3315 Brighton St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) NOV 24 1947 207 W. North Ave.,

19 (a) ____ (Date rec'd by registrar) (b) Funeral Director Baltimore, Md.

correct age is especially important if possible

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22/47 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1947 to 11/22 1947 and that I last saw him alive on 11/22 1947

Immediate cause of death	Duration
CONGESTIVE HEART FAILURE	
Due to MITRAL STENOSIS & INSUFFICIENCY	
Due to CHRONIC RHEMATIC HEART DISEASE	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
RHEUMATIC CARDIOVALVULAR DISEASE of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Gareis Jr. M.D.
Address 207 W North Ave Date signed 11/22/47

VS 150

57217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G57217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Wilkens Ave
(c) Hospital or institution: 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas F. Corcoran

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Katherine Burke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28th 1870

8. AGE: Years 77 | Months 9 | Days 26 | If less than one day ____hr. ____min.

9. Birthplace Ireland (Town, county, and state or foreign country)
10. Usual Occupation Retired B'tmr P.P.
11. Industry or business Boiler maker

FATHER
12. Name Marcus Corcoran
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Sullivan
15. Birthplace Ireland

16 (a) Informant Mrs Walter B. Corcoran
(b) Address 1608 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 43rd & Old Frederick Rd

18 (a) Funeral director John F. Gannon & Son
(b) Address 907-09 Hollins St.

19 (a) NOV 24 1947 (b) Huntington Williamsport

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23rd 1947, at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1947 to Nov 23 1947, and that I last saw him alive on Nov 23 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Racusin M. D.
Address 206 S. Gilmor St. Date signed 11-24-47

X

57248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 52a

Registered No. 657248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20-1
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1952 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mr. William Smyser

3 (b) If veteran, name war .....
3 (c) Social Security account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11/11/81

8. AGE: Years	Months	Days	If less than one day
66	0	10	..... hr. ..... min.

9. Birthplace Hartenbay (Town, county, and state)
10. Usual Occupation Railroad Engineer
11. Industry or business Steam
12. Name John Smyser — FATHER
13. Birthplace Ky
14. Maiden Name Hall — MOTHER
15. Birthplace Ky
16 (a) Informant Kept Record
(b) Address .....
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-47 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore Md
18 (a) Funeral director Geo. A. Farley
(b) Address Fulton & Fayette
19 (a) NOV 24, 1947 (b) Huntingtown, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1947, at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1947 to Nov. 22 1947 and that I last saw him alive on Nov. 21 1947

Immediate cause of death Cardiac and respiratory failure — Duration .....
Due to Marked debility and cachexia. — Duration .....
Due to Carcinoma of unknown origin. — Duration .....
Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: Hypernephroma left kid with metastases to liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....
23. Signature Paul D. Mannion M. D.
Address Bon Secours Hosp. Date signed 11/22/47

correct age is especially important for persons under one year

VS 150

57249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. 57249

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST. JOSEPH'S HOSP 25-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 S. HANOVER
(If rural give location)
(e) Citizen of foreign country? N.D. (Yes or No)
If yes, name country

3 (a) FULL NAME REINER, LYDIA E

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife CHARLES M.
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1887

8. AGE: Years	Months	Days	If less than one day
60	7	8	hr. min.

9. Birthplace Mauch PENNSYLVANIA (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. F. Bickt
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Bickt
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Charles Reiner
(b) Address 3908 S. Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27 '47 (month) (day) (year)
(c) Cemetery or crematory Fairview Cemetery
Location Mauch Pennsylvania

18 (a) Funeral director Reigle Funeral Home
(b) Address Millersburg Pennsylvania

19 NOV 24 1947 (Date rec'd by Registrar) [signature] Millersburg

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1947, at 6.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1947 to 11/23 1947, and that I last saw her alive on 11/23 1947

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to PERITONITIS	
Due to STRANGULATED VENTRAL HERNIA	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: STRANGULATED VENTRAL HERNIA
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry D. Carter M.D.
Address ST. JOSEPH'S HOSP Date signed 11/28/47

X

657250 3 BALTIMORE CITY HEALTH DEPARTMENT 657250

CERTIFICATE OF DEATH 54a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 S Highland Ave
(c) Hospital or institution: 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 S Highland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Imodha Malone

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 - 1908

8. AGE: Years	Months	Days	If less than one day
39	10	13	hr. min.

9. Birthplace Penna
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Mankowski
13. Birthplace Poland

MOTHER
14. Maiden Name Adele Brockowski
15. Birthplace Poland

16 (a) Informant George Malone
(b) Address 900 S Highland.

17 (a) Burial (b) Date thereof 11-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Edmondson Hill Rd

18 (a) Funeral director John P Connolly
(b) Address 4 N Gaston Ave

19 (a) NOV 24 1947 (b) Wm. J. Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 19 47, at 7:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 47, to Nov. 19 47 and that I last saw her alive on Nov. 18 19 47

Immediate cause of death Brain Tumor (Glioma) — Duration 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation July 15 1947
Major findings of operation Malignant tumor right side of brain.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Clarence W. LeBoeuf M.D.
Address 601 E Edmondson Ave Date signed 11/24/47

57251 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp 268
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 S. Eaton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louise Katherine Tonazzo

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife. August B. Tonazzo.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/31/1874

8. AGE: Years 72 | Months 11/10 | Days 10/20 | If less than one day hr. min.

9. Birthplace Towson, Md.
(Town, county, and state)

10. Usual Occupation Housf.

11. Industry or business

FATHER 12. Name Unk Walker
13. Birthplace Unk

MOTHER 14. Maiden Name
15. Birthplace "

16 (a) Informant August B. Tonazzo
(b) Address 222 S. Eaton St.

17 (a) Burial (b) Date thereof 11-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Dulaney Valley Rd

18 (a) Funeral director John B. Connelly
(b) Address 41 E. Eutaw St.

19 NOV 24 1947 (Date rec'd by registrar) Washington Wilkinson

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1947, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1947 to 11/20 1947, and that I last saw her alive on 11/20 1947.

Immediate cause of death	Duration
Cerebro vascular accident	
Due to Arteriosclerotic heart disease (Generalized	
Due to arteriosclerosis)	
Other Conditions Congestive heart failure - Hypostatic pneumonia	

(Include pregnancy within)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M.D.
Address 1400 N. Caroline St. Date signed 11/20/47

X

57252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 657252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 Legal St 241
(c) Hospital or institution: South Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Andrew St (30)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Pevola Sr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 232-10-2890

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Helen Pevola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 1884

8. AGE: Years	Months	Days	If less than one day
63	9	15	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Coal Miner
11. Industry or business

FATHER
12. Name Frank Pevola
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Son Frank Pevola
(b) Address 1313 Andrew St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Grove
Location Morgantown W. Va.

18 (a) Funeral director Charles F. Hall
(b) Address 150 [illegible] Williams, W. Va.

NOV 24 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1947, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1947, to Nov 23 1947, and that I last saw h[illegible] alive on Nov 23 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	48 hrs
Due to Generalized Arterio-sclerosis	
Due to Arteriosclerotic Heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harold Dillon M. D.
Address South Balto Gen. Date signed 11/23

correct age is especially important. Physicians, please

VS 150

3572253

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V 170 C

Registered No. 3572253

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Myrtle Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME JAMES DOUGLAS BATTY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 2, 1938

8. AGE: Years 9 | Months 10 | Days 21 | If less than one day ....hr. ....min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation School Child

11. Industry or business

FATHER
12. Name James Batty
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Beatrice Russell
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs Beatrice Batty
(b) Address 1414 Myrtle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 27 (month) (day) (year) 1947

(c) Cemetery or crematory Auburn Memorial Park
Location Baltimore County Md

18 (a) Funeral director Joseph A. Luzy
(b) Address 661 W Baltimore street

19 (a) Date received by local registrar NOV 24 1947 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1947, at 3.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, traumatic

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 14/2

(a) Date of injury 11-20-47 at 3 P. M.

(b) Where did injury occur? Lafayette & Division St Baltimore, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian-struck by auto

23. Signature Emil Kyle M.D.
Medical Examiner.

Date signed 11-24-47

X

G57254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G57254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 E Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dr. Maxwell L. Mayer Mayer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	D.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace New York N. Y. (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Abraham Mazer
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Dr Robert Mazer
(b) Address 6426 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25/47 (month) (day) (year)
(c) Cemetery or crematory Arlington Cemetry Rogers ave
Location

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) Nov 24 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1947, at 11:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1947 to Nov 23 1947, and that I last saw h.i.m alive on Nov. 23 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Coronary Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 11/25/47

VS 150

X

7255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

Registered No. 057255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's.
(c) City or town Leonardtown
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME George S. Cusic

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12/31/20

8. AGE: Years 26 | Months 10 | Days 24 | If less than one day .....hr. .....min.

9. Birthplace SMT. Leonardtown
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Joseph Cusick
13. Birthplace Leonardtown, Md

MOTHER
14. Maiden Name Daisy Adams
15. Birthplace Leonardtown, Md

16 (a) Informant.....
(b) Address.....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Morganza, Md.

18 (a) Funeral director W. D. Mattingley Sons.
(b) Address Leonardtown, Md.

19 NOV 24 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1947, at 8 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured vertebrae
Fractured pelvis
Rupture of bladder
Intra abdominal hemorrhage

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-23-47 at ..... P.M.
(b) Where did injury occur? Oakville Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto. ran off road into tree

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 11/24/47

7256 Med. Exam Case 442446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. 657256

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Lafayette Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME James Ugguns

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-05-1904

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col.	single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-20-96

8. AGE: Years	Months	Days	If less than one day
51	8mo	2	..... hr. ..... min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Uggums
13. Birthplace Va.

MOTHER
14. Maiden Name Martha ?
15. Birthplace Va ?

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn
18 (a) Funeral director Jno Brooks (Clifford)
(b) Address 1463 N. Carey St
19 (a) Nov 24 1947 (Signature of Registrar) (Title) Asst. Registrar
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1947 at 8 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13-1947 to 11-22-1947 and that I last saw him alive on 11-22-1947

Immediate cause of death: Cardio-vascular Collapse — Duration: 6 Min
Due to: Rt. pneumonectomy — 2 hrs
Due to: Carcinoma of rt. Lung — 8 Mos
Other Conditions: Metastasis - Extension to vena
(Include pregnancy within 3 months of death)
Date of operation 11/22/47
Major findings of operation: Carcinoma of rt. lung. Adherent to heart + diaphragm
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....(Specify type of place)
(e) Means of injury.....
23. Signature Milton Edgerton
Address Hopkins Hospital Date signed 11/23 D.

X

572257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 572257

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 E. 31st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 E. 31st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LAWRENCE W. WARREN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ada R. Warren (nee De Shon) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1870

8. AGE: Years	Months	Days	If less than one day
77	4	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Superior Court Balto.
11. Industry or business Record Office

FATHER
12. Name Samuel J. Warren
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine Parry
15 Birthplace Md.

16 (a) Informant Mr. L. Whitridge Warren
(b) Address 1627 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery or crematory Asbury Methodist Cem.
Location Reisterstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 24 1947 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1947 to Nov. 22 1947 and that I last saw him alive on Nov. 21 1947.

Immediate cause of death	Duration
Hy. enuretis	1 yr.
Due to Uterus sclerosis	
Due to	
Other Conditions Operation on Ureter urinary Calculus Bladder.	Aug 1947.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Louis Frohn M. D.
Address 1826 N. Wood. St. Date signed 11/24/47

G57258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓171a

Registered No. G57258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. D. O. A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Huntingdon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie May Howell

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife John B. Howell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1882

8. AGE: Years	Months	Days	If less than one day
65	2	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Theodore H. Morrison
13. Birthplace Md.

MOTHER
14. Maiden Name Ann Downey
15. Birthplace Md.

16 (a) Informant Mr. Lloyd Howell
(b) Address 2913 Huntingdon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. [illegible] Williams, Md.
(b) Address Balto., Md.

19 NOV 24 1947 (Date rec'd by registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 1947, at 7:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/22/47 at 7:40 P.M. 12/7
(b) Where did injury occur? 31st & Huntington Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No
Means of injury Ford automobile & street car

23. Signature Earl L. Phelps M.D. Medical Examiner.
Date signed 11/23/47

X

G57259 Subert

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith Street
(c) Hospital or institution:
Convent Infirmary of Notre Dame
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith Street (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3 (a) FULL NAME
Sr. Mary Thekla Ottilia Seubert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Dec 1855

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/20/54

8. AGE: Years 92 | Months 11 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name Francis Anton Seubert
13. Birthplace Germany

MOTHER
14. Maiden Name Josepha Bausbach
15. Birthplace Germany

16 (a) Informant Sr. M. Stan. Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26th. 47 (month) (day) (year)
(c) Cemetery or crematory Notch Cliff
Location Glen Arm/

18 (a) Funeral director Geo. M. Fink & Son,
(b) Address 811 N. Wolfe St.

18 (c) (Registered by registrar) Nov 24 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1947, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1926, to November 1947, and that I last saw h[illegible] alive on November 1947.

Immediate cause of death	Duration
Congestive heart failure	
Due to Enteroptosis	
Due to Chr Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Kirby
Address 1108 North Ave Date signed 11/24/47

Direct age is especially important. If impossible, approximate.

657260

442408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157F

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Holden. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Owen Cable.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-5-34

8. AGE: Years	Months	Days	If less than one day
13	3	19	hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation
11. Industry or business School

FATHER
12. Name Frederic Cable
13. Birthplace Alg.

MOTHER
14. Maiden Name Maude Dingiss
15. Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 28th 1947 (month) (day) (year)
(c) Cemetery or crematory Baisden Cemetery
Location Logan W. Va.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) Nov 24 1947 (b) (Date received by registrar)

Huntington, W. Va. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24- 1947, at 1 45' A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11- 1947 to 11-24- 1947 and that I last saw him alive on 11-24- 1947

Immediate cause of death	Duration
Cerebral Thrombosis	2 days
Due to Coarctation of Aorta, aneurism of	Life
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-19-47

Major findings of operation: Coarctation of aorta

of autopsy: Cerebral Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Clary M. D.

Address Johns Hopkins Hosp. Date signed Nov 28 1947

X

G57261I

442145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

G57261I

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town ~~Kountze~~ Beaumont (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country ~~Persian Gulf~~

3 (a) FULL NAME Thomas E Patrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Janie Patrick (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 11-17-10

8. AGE: Years	Months	Days	If less than one day
37 36	-	7	..... hr. ..... min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation

11. Industry or business Oil

FATHER
12. Name Frank Patrick
13. Birthplace Texas

MOTHER
14. Maiden Name Tippie Hooks
15. Birthplace Texas

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 25th/47 (month) (day) (year)
(c) Cemetery or crematory
Location Hamilton Texas

18 (a) Funeral director Henry W. Jenkins Sons
(b) Address Mt. Calvert & Orchard Sts

Nov 24 1947 (Date rec'd by registrar) [illegible] Williams, M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 - 1947 at 5-37 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10- 1947 to 11-24- 1947 and that I last saw him alive on 11-24- 1947

Immediate cause of death Cerebral Edema

Duration
24 hrs.

Due to Edema of Brain Tumor

Duration
5 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/21/47

Major findings of operation: Edema & Cerebellum

of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur B Long

Address Johns Hopkins Hosp Date signed 11/24/47

G57262 BALTIMORE CITY HEALTH DEPARTMENT G57262

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3630 Elm Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Currie

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex Male | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced.** Widowed

6 (b) Name of husband or wife Susan Ann Currie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1864

8. AGE: Years 83 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Mr. Currie
13. Birthplace Scotland

MOTHER
14. Maiden Name Unknown
15. Birthplace Scotland

16 (a) Informant Mr. Henry Mitchell
(b) Address Southern Hotel

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov. 25, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director [illegible] & Donovan
(b) Address 2510 Liberty Heights Ave.

19 NOV 24 1947 (b) [illegible] Registrar
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Nov 1947, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Snyder M.D.
Medical Examiner.
Date signed 23 Nov 47

VS 151

G57263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G57263

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 N Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Kieffer W.Va
(If outside city or town limits, write RURAL and give town)
(d) Street No. Kieffer W Va
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Blankenship

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Marc 26,1893

8. AGE: Years	Months	Days	If less than one day
54	7	28	hr. min.

9. Birthplace W Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Charles Hamrick
13. Birthplace W Va

MOTHER
14. Maiden Name Martha Lewis
15. Birthplace W Va

16 (a) Informant Edward Blankenship
(b) Address Kieffer W Va

17 (a) Burial (b) Date thereof Nov 24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Roncevert W Va
Location West Virginia

18 (a) Funeral director Sol Lewis and Bro
(b) Address 1124-26 W Baltimore

19 (a) (b) Registrar

NOV 24 1947

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1947 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Nov 13 1947
and that I last saw h[illegible] alive on 19
Immediate cause of death Exhaustion from
after Cancer - treatment
Due to Cancer of bladder about 2 yrs.
Due to
Other Conditions Metastasis - of Cancer
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Opened of bladder - left in
of autopsy: Veit-Virginia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. Trawott M. D.
Address 1623 E. N. Ave Date signed 11/13/47

Correct age is especially important if deceased was under one year or one day

264

657264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 W. Fayette st
(c) Hospital or institution: 4-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 W. Fayette st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Minnie O'Rourke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or~~ divorced. Married

6 (b) Name of husband ~~or wife~~ Robert O'Rourke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13th 1875

8. AGE: Years	Months	Days	If less than one day
72	9	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name William A. Waxter
13. Birthplace Germany

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Germany

16 (a) Informant Robert O'Rourke
(b) Address 702 W. Fayette St

17 (a) Burial (b) Date thereof 11/26/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 NOV 25 1947 (b) Huntington Williams Jr
(Date rec'd by registrar)

correct age is especially important

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22nd 1947, at 6-15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18/47 19 to 11/22/47 19
and that I last saw h~~e~~r alive on 11/18/47 19

Immediate cause of death

Endocarditis

Due to

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter F. Bowers M. D.

Address 401 E Edmondson Date signed 11-26-47

X

7265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓1147

G57265 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or ~~town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 N. Baltimore Ahead
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Summers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of ~~husband or~~ wife Lorraine Summers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1891

8. AGE: Years	Months	Days	If less than one day
56	4		hr. min.

9. Birthplace Illinois
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business American Oil Co

FATHER
12. Name (Unknown) Summers
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Lorraine Summers
(b) Address 616 W. Balto. St.

17 (a) Burial (b) Date thereof 11/26/47
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory ~~U.S. National~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

NOV 25 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/47 19 2:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lung Abscess

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 11/24/47

268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G57266

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 E. Fayette St.
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Gustav Carl Radke

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife Rose Ziegler Radke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1873

8. AGE: Years 74 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation retired bricklayer
11. Industry or business

FATHER
12. Name Karl Radke
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Anne Serra
(b) Address 2817 Alvorado Square

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location O'Donnell St. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) NOV 25 1947 (Date received by registrar) (b) Registrar

Copies are not obtainable from this registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23- 1947 at 7.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13- 1947 to 11-23- 1947, and that I last saw h. alive on 11-23- 1947

Immediate cause of death	Duration
Bronchopneumonia	1 day
Due to Cerebral Hemorrhage	4 days
Due to Arteriosclerosis	10 years
Other Conditions Diabetes Mellitus	7 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Wilson M. D.
Address 648 N. Linwood Ave Date signed 11-24-47

83a

267 BD# 2.79046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157M

Registered No. 657267

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible] 265
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S. Rappolla St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country — — —

3 (a) **FULL NAME** Thelma Rinaca

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17 1947

8. AGE: Years 0 | Months 6 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name Guy Rinaca

13. Birthplace Virginia

MOTHER 14. Maiden Name Trilba Homedon

15. Birthplace Virginia

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11-25-1947 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.

Location Eastern Ave. Extension

18 (a) Funeral director Lilly & Zeiler Inc.

(b) Address 403 S. Wolfe Street

19 (a) [illegible] (b) [illegible] Huntington Williams M.D. Registrar

NOV 25 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1947 at 9 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1947 to 11-23 1947, and that I last saw her alive on 11-23 1947.

	Duration
Immediate cause of death: Aspiration	
Due to: Atelectasis - right middle lobe	3 days
Due to: Congenital Conjenita	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-22-47

Major findings of operation: Tracheotomy

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address Johns Hopkins Hosp. Date signed 11-23-47 M. D.

X

7268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1241B

Registered No. G57268

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Dr. & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 S. Patterson Pk. Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lind, Thomas Henry

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No. 215-09-0634

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1897

8. AGE: Years 50 | Months 10 12 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation seaman
11. Industry or business Merchant Marine

FATHER
12. Name Michael Lind
13. Birthplace York, Pa.

MOTHER
14. Maiden Name Margaret Reagan
15 Birthplace Baltimore, Md.

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Edmondson Avenue

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe Street

NOV 25 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1947 at 12:16a

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11, 1947 to Nov. 23, 1947 and that I last saw h... alive on Nov. 23, 1947.

Immediate cause of death	Duration
Cirrhosis of liver	
Hemorrhage from ruptured esophageal varices	24 hrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos M. Chisolm M. D.
Address USM Marine Hospital Date signed 11/23/47

7269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G57269 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Brookwood Road (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Walter H. Megenhardt

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 212-09-0105

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Esther R. Megenhardt
6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1898

8. AGE: Years 48 | Months 10 | Days 30 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Staff Assistant
11. Industry or business: Standard Oil Co.

FATHER
12. Name: Charles Megenhardt
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Sadie Roe
15. Birthplace: Maryland

16 (a) Informant: Esther R. Magenhardt
(b) Address: 609 Brookwood Rd.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Park
Location: Woodlawn, Md.

18 (a) Funeral director: George W. Little
(b) Address: 2700 Edmondson Ave.

NOV 25 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1947, at 12:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1947, to Nov. 24 1947, and that I last saw him alive on Nov. 24 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John D. Monteath, M.D.
Address: 1401 St. Paul St. Date signed 11-24-47

7270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. 157270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Windsor Ave.
(c) Hospital or institution: 166
Windsor Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2876 W. Lanvale St.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Bell Hamp

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FM	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1875

8. AGE: Years	Months	Days	If less than one day
72 71	6	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John H. Hamp
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Jacobs
15. Birthplace Md.

16 (a) Informant Mr. A. Steinback
(b) Address 3603 Gelston Drive

17 (a) Burial (b) Date thereof 11/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 NOV 25 1947 Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1947 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7th 1947, to Nov 22nd 1947, and that I last saw h alive on Nov 3rd 1947.

Immediate cause of death Duodenal Cancer — Duration 9 days

Due to Diabetes Mellitus — 30 years

Due to

Other Conditions Symptoms of Cancer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Nov 25 1947

B-57271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 150

B-57271 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1822 St. Paul St.
(c) Hospital or institution: none 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 St. Paul St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Louise Craig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Prof. Thomas Craig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1858

8. AGE: Years 89 | Months 1 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Oregon (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Benjamin Alvord
13. Birthplace Vt.

MOTHER
14. Maiden Name Emily L. Mussey
15. Birthplace Vt.

16 (a) Informant Miss Ethel Craig
(b) Address 1822 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director James O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 26 1947 (Date received by registrar) (b) Curtis A. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1947, at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1912 to Nov. 23 1947 and that I last saw h~~e~~ alive on Nov 18 1947

Immediate cause of death Carcinomatosis of abdomen with metastases — Duration 18 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Holmes Bond, M.D.
Address 24 E. Eager St. Date signed 11/24/47

correct age is especially important. Physician, please write plainly.

VS 150

9272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G57272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Monument St
(c) Hospital or institution: Sinai 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 No Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS EVA STEINHORN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Abe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Wolf Lakhokort
13. Birthplace: Russia

MOTHER
14. Maiden Name: Katie
15. Birthplace: Russia

16 (a) Informant: Abe Steinhorn
(b) Address: 1538 No Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-47 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship
Location:

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2160 Eutaw Place

19 (a) NOV 25 1947 (Date filed by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1947, at 5 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1947 to Nov 24 1947 and that I last saw h alive on Nov 24 1947

Immediate cause of death: Uremia — Duration

Due to: Chronic Glomerulo-nephritis

Due to:

Other Conditions: Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Allan Y. Wolinsky M. D.
Address: Sinai Hosp Date signed 11-26-47

VS 150

7273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. 657273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4830 Belair Road
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4830 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Markin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie
15. Birthplace Russia

16 (a) Informant Samuel Markin
(b) Address 4101 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-47 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

19 NOV 25 1947 (Date rec'd by local registrar) (b) Burlington-Williamsport, Md.

V S 150

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1947, at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1946 to Nov. 24 1947, and that I last saw her alive on Nov. 23 1947.

Immediate cause of death Uremia — Duration 6 months
Cardiac failure — 7 years
Due to Chronic pyelonephritis
Due to
Other Conditions Diabetes mellitus, Hypertensive Cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert M. Gundersheimer, Jr. M. D.
Address Riviera Apts Fall Drive Date signed Nov. 24/1947

133a

2724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓93a

Registered No. 652724

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 Etting St.
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Etting (If rural give location)
(e) Citizen of foreign country? Md (Yes or No) If yes, name country

3 (a) FULL NAME JOHN FREDERICK HARRIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
W.W.#1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/14/1892

8. AGE: Years	Months	Days	If less than one day
55	7	6 7	hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Albert Harris
13. Birthplace Rock, Md.

MOTHER
14. Maiden Name Josephine Parker
15. Birthplace Eastern Shore, Md.

16 (a) Informant Louise Harris (Wife)
(b) Address 1209 Cotting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore, Nat'l
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) NOV 25 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21st 1947, at 3AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1947, to 11/21 1947 and that I last saw h[illegible] alive on 11-21 1947.

Immediate cause of death	Duration
Uremic Myocardial Infection	3 Days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1 W Ave Date signed 11/25/47

X

275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 657275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 34 S. Fremont Ave
(c) Hospital or institution: 183
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 S. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanley Beresunas

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years: 78 | Months | Days | If less than one day: hr. min.

9. Birthplace: Lith (Town, county, and state)

10. Usual Occupation: Retire

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant: Elizabeth Beresunas
(b) Address: 34 S. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25-47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd

18 (a) Funeral director: Joseph Kaminskas
(b) Address: 417 W Washington Ave

19 (a) NOV 25 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1947, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4th 1947 to Oct 28th 1947, and that I last saw h/m alive on Oct 28th 1947.

Immediate cause of death	Duration
CARCINOMA of COLON & STOMACH	
Due to	
Due to	
Other Conditions BLADDER CALCULUS - URINARY	

(Include pregnancy within 3 months of death)

Date of operation Oct 9th 1947

Major findings of operation: BLADDER STONE - Lymph GLAND - CARCINOMATOUS.

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis A. Gillin M. D.

Address 1800 N. Charles St. Date signed 11/24/47

Correct age is especially important if deceased was under one year or one day.

276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57276
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 S. Linwood Ave.
(c) Hospital or institution:
None
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Marylans (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 S. Linwood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME HENRY S. McCLALLY

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Sarah Jane Sollers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9, 1864

8. AGE: Years	Months	Days	If less than one day
83	1	12	..... hr. ..... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Thelma McClally
(b) Address 912 S. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St.

19 NOV 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1947, at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1947 to Nov. 21, 1947 and that I last saw h/m alive on Nov. 21, 1947

Immediate cause of death	Duration
(1) Broncho-pneumonia (Rt. u.l.f. base posteriorly)	4 days
Due to (2) Arteriosclerotic Cardio-vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Ehrlich M.D.
Address 504 Queensberry Ave Date signed 11/24/47

Howard J. Mullen M.D.

7277

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓97

G57277
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5109 Ardmore Way
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5109 Ardmore Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas H. Stetser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Emma S. Greaser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1859

8. AGE: Years	Months	Days	If less than one day
88	1	3	hr. min.

9. Birthplace New Jersey
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John C.
13. Birthplace N.J.

MOTHER
14. Maiden Name Light Carter
15. Birthplace N.J.

16 (a) Informant Mrs. Mamie G. Murray
(b) Address 5109 Ardmore Way.

17 (a) Burial (b) Date thereof 11/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Md.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 NOV 25 1947 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

Correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1947, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from October 10 1947, to Nov. 22 1947, and that I last saw him alive on Nov 22 1947.

Immediate cause of death: Generalized Arteriosclerosis — Duration: 10 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Lachman (M.D.)
Address 4930 Belair Rd Date signed Nov 24, 1947
M. D.

X

7278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57278 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo 25 DAYS

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2125 Madison Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country None

3 (a) FULL NAME India Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fe

5. Color or race Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Elmer Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1889

8. AGE: Years 58 | Months 4 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Longgreen, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Jerry Mason

13. Birthplace Md.

MOTHER

14. Maiden Name Sallie Hall

15. Birthplace Md.

16 (a) Informant Mr. Ridgley Robinson

(b) Address 2123 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem.

Location Longgreen, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) NOV 25 1947 (Date rec'd by registrar) (b) Huntingtor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1947, at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1947, to Nov. 22 1947, and that I last saw her alive on Nov 22 1947.

Immediate cause of death Subarachnoid Hemorrhage — Duration 1 Day

Due to Hypertensive C-V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William M. Garner, M.D.

Address 1514 Division St Date signed 11/24/47

VS 150

X

279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G57279

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp.
(c) Hospital or institution: 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 E Lombard st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Price — John J. Price —

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-1752

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Anna Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20 - 1888

8. AGE: Years	Months	Days	If less than one day
59	10	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business Columbia Specialty Co.

FATHER
12. Name Joseph Price
13. Birthplace Balto.

MOTHER
14. Maiden Name Anna Werner
15. Birthplace Ger.

16 (a) Informant Mrs Anna Price
(b) Address 1926 E. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Aliceanna st.

NOV 25 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1947, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23, 1947, to Nov 23, 1947 and that I last saw h[illegible] alive on Nov 23, 1947.

Immediate cause of death	Duration
(a) Shock	
Due to (b) Perforating gastric ulcer; peritonitis; pelvic abscess	
Due to (c)	
Other Conditions Bronchogenic carcinoma	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: (a) (b) above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Phillips.
Address [illegible] Date signed 11/24/47 M. D.

In a Hosp. Referred to Dr. [illegible] M.D.

280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G57280 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: So. Balto. Genl Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Pennington Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DR. LEON S. HORKA

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife [redacted] Mrs. Mary Horka
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Mar 24, 1886

8. AGE: Years	Months	Days	If less than one day
61	8	0	hrs. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business Medicine

FATHER
12. Name Joseph Horka
13. Birthplace Europe

MOTHER
14. Maiden Name Anna Nowakorki
15. Birthplace Poland

16 (a) Informant Wife
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem. Brooklyn
Location Gov. Ritchie Highway

18 (a) Funeral director Milton D. Schilling
(b) Address 3914 Hanover St - 25 —

19 (a) Nov 5 1947 (Date received by Registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1947, at 6.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1947 to Nov 24, 1947 and that I last saw h[illegible] alive on Nov 24, 1947

Immediate cause of death: Cute coronary occlusion — Duration
Due to: coronary sclerosis
Due to:
Other Conditions: Rt Bronchopneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon S. Horka M. D.
Address 1213 Light St Date signed 11/24/47

correct age is especially important. Physicians, please

VS 150

7281 369834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30c

G57281 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 E Biddle, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Fell.

3 (b) If veteran, name war

3 (c) Social Security Account No. 088-05-6255

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-18-(8?)1879

8. AGE: Years	Months	Days	If less than one day
67	11	6	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Packager
11. Industry or business

FATHER
12. Name John Fell ?
13. Birthplace Baltimore ?

MOTHER
14. Maiden Name Lena Sauberger?
15. Birthplace Maryland ?

16 (a) Informant Mrs Anna Kiszner
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov 26-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location

18 (a) Funeral director Chas P Powell
(b) Address 2427 Edmondson Ave

NOV 25 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 - 1947, at 12 01 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19- 1947 to 11-24-1947 and that I last saw h[illegible] alive on 11-24- 1947

Immediate cause of death CNS syphilis — Duration 15 yrs?
Due to
Due to
Other Conditions Cardio-vascular syphilis with aortic insuff. (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Victor A. McKusick
Address Johns Hopkins Hosp Date signed 11/24 M. D.

7282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G57282 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4911 Toone St.
(c) Hospital or institution: 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4911 Toone St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret E. Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1881

8. AGE: Years	Months	Days	If less than one day
66	10	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Hoffman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Minnie Miller
15. Birthplace Baltimore

16 (a) Informant Louis Wise
(b) Address 1355 S. Ponca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 NOV 25 1947 (Date filed by Registrar) (b) Turlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1947, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1947, to Nov. 22, 1947, and that I last saw her alive on Nov. 22, 1947.

Immediate cause of death	Duration
Coronary Thrombosis	2 wks (?)
Due to 1) Arteriosclerotic Cardiovascular Disease	
Due to 2) Diabetes	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Ehrlich, M.D.
Address 5024 Queens Derry Ave Date signed 11/24/47
Howard J. Mullin, M.D.

VS 150

Correct, sec. 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23

283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 S. Patterson Pk Ave
(c) Hospital or institution: 1-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 S. Patterson Pk ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Popiacki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name Agatha
15 Birthplace Poland

16 (a) Informant Jean Vestal
(b) Address 2611 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 NOV 25 1947 (Date received by registrar) [illegible] for Williams M.D. Registrar

V S 150

correct age if especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1947 to Nov 23 1947 and that I last saw h[illegible] alive on Nov 23 1947.

Immediate cause of death	Duration
CORONARY OCCLUSION	11/23/47
Due to ARTERIOSCLEROTIC CARDIO-VASCULAR	
Due to DISEASE	6 MOS.
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] F Drenga M.D.
Address 209 E Chester St Date signed 11/25/47

X

57284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83a

G57284 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 27-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 2821 Huntingdon Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Vaeth

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9/28/1871

8. AGE: Years	Months	Days	If less than one day
76	2 1	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Pastor
11. Industry or business

FATHER
12. Name ANGELINA VAETH
13. Birthplace GERMANY

MOTHER
14. Maiden Name [illegible] MIERS
15. Birthplace Germany

16 (a) Informant Mayhew
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director D. J. Rafferty & Son
(b) Address 1131 E Light St

NOV 25 1947 (Date filed by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1947, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1947 to Nov 24 1947, and that I last saw h.r. alive on Nov 24 1947

Immediate cause of death Cerebral Hemorrhage

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. [illegible]
Address Mercy Hosp. Date signed 11/24/47 M. D.

correct age is especially important. Physicians: please w

VS 150

X

285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

657285
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 N Streetwest
(c) Hospital or institution: 19-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 417 N Streetw, Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 21 Streetw st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lettie E. Boardley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	Married

6 (b) Name of husband or wife Wesley
6 (c) If alive, give age 90 years

7. Birth date of deceased (mo., day, yr.) Feb 17, 1868

8. AGE: Years	Months	Days	If less than one day
79	9	6	hr. min.

9. Birthplace Elicott city, Md
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Alfred Clifford
13. Birthplace Elicott city, Md

MOTHER
14. Maiden Name Marcella Clifford
15. Birthplace Md

16 (a) Informant Arthur Boardley
(b) Address 417 N. Streetwest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 NOV 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

correct age is especially important

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947, to Nov 23 1947, and that I last saw h alive on Nov 23 1947.

Immediate cause of death	Duration
Apoplexy	5 Hours
Due to Mitral Insufficiency	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edw. Fisher M. D.
1642 E Monument Date signed 11/47

X

286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

657286 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 S. Chapelgate Lane
(c) Hospital or institution:
Pine Crest Nursing Home 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 Ilchester Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT ROBERTS

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 212-07-0327

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife (if married, widowed, or divorced)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1878

8. AGE: Years 69 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Frye Roberts
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Emma Scott
15 Birthplace Md.

16 (a) Informant Mrs. Hayes Pitcher
(b) Address 303 Ilchester Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 25 1947 (Date rec'd by registrar) Huntington Williams, M.D.

V S 150

correct this if erroneously supplied

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1947, at 9:15a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to Nov. 23 1947 and that I last saw h[illegible] alive on Nov. 22 1947

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Arthur Rosebrough M.D.
M. D.
Address 2411 Washington Blvd. Date signed 11/24/47

7287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

Registered No. 657287

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 271
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Tyndale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Percy Jr. Irwin

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Viola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 1900

8. AGE: Years	Months	Days	If less than one day
47	6	12	hr. min.

9. Birthplace Barree, Pa. (Town, county, and state)
10. Usual Occupation Sup't Electrical Traction
11. Industry or business P.R.R.

FATHER
12. Name Landis J. Irwin
13. Birthplace Center Co. Pa.

MOTHER
14. Maiden Name Elizabeth Borst
15. Birthplace Pa.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery or crematory Petersburg, Pa.
Location Perterburg Pa.

18 (a) Funeral director William J. Lickner & Sons
(b) Address North & Pennsylvania Aves

NOV 25 1947 (Date rec'd by Registrar) (b) Huntingdon, Pa.

correct age is especially important if under 1 year or 100 years

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1947, at 11 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1947 to Nov 24 1947 and that I last saw h[illegible] alive on Nov 24 1947.

Principal cause of death	Duration
Disseminated Sclerosis	4 yrs
Due to Pneumogastric disease	Acute 1½ hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: Autopsy
of autopsy: Negative other disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11-24-47

VS 150

7888-A B.C. 19+960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

Registered No. 057288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Dukeland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Ward

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1947

8. AGE: Years — | Months — | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Maurice Ward
13. Birthplace Towson, Md.

MOTHER
14. Maiden Name Pauline Moody
15. Birthplace Towson, Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25 1947 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Md.

18 (a) Funeral director Johns Burns Hopkins
(b) Address Towson, Md.

19 (Date rec'd by registrar) NOV 25 1947 (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1947, at 3-20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19..., and that I last saw her alive on 11/24 1947.

Immediate cause of death D. O. A. — Duration

Due to ? INTESTINAL OBSTRUCTION

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: VERBAL PERFORATION OF SIGMOID-CANCER

Autopsy: GENERALIZED PERITONITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. A. Sparks, M.D.
Address Johns Hopkins Hospital M.D. Date signed 11/24/47

To be approved by medical Examiner
Howard J. Kunewick M.D.

Correct age if especially important

VS 150

289
BC45-95586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registered No. 657289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital. 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 23 Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2687 Dulaney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Blair.

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25th 1947

8. AGE: Years	Months	Days	If less than one day
			4½ hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Robert Blair.
13. Birthplace Baltimore, Maryland.

MOTHER
14. Maiden Name Ruth Emily Necker.
15. Birthplace Baltimore, Maryland.

16 (a) Informant Mrs Ruth Emily N. Blair.
(b) Address 2687 Delany St. Balto-23

17 (a) Burial (b) Date thereof 11 26 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3901 Frederick Rd.

18 (a) Funeral director John J. Coyne & Son
(b) Address 901-03 Hollins St.

19 NOV 25 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

correct age is especially important. Registrar's

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25-47 19..., at 12 o'clock M

21. I certify that death occurred on the date above stated; that I attended deceased from 19... to 19...
and that I last saw h... alive on 19...

Immediate cause of death Respiratory Failure — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cecil Nelson M. D.
Address Bon Secours Hosp Date signed 11-25

7290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

657230

Registered No. 164 c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 752 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Rose

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	233-07-7352	M	W	Married

6 (b) Name of husband or wife Stella Orvilla Rose
6 (c) If alive, give age 33 years
7. Birth date of deceased (mo., day, yr.) Feb. 10, 1910

8. AGE: Years	Months	Days	If less than one day
37	9	14	hr. min.

9. Birthplace Webster Springs, W. Va.
(Town, county and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business Doughnut Corp. of America

FATHER
12. Name George Edward Rose
13. Birthplace West Virginia

MOTHER
14. Maiden Name Nancie Sizemore
15. Birthplace West Virginia

16 (a) Informant Mrs. Stella Rose
(b) Address 752 Frederick Ave, Catonsville
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27, 1947 (month) (day) (year)
(c) Cemetery or crematory Fairview Cemetery
Location Fairview, W. Va.
18 (a) Funeral director Easton Sons
(b) Address 608 Fred. Ave. Catonsville
19 NOV 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/1947, at 6 PM M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of head
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/24/47 at about 12 A M.
(b) Where did injury occur? Village Inn - and Frederick Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Tavern While at work? No
(d) Means of injury Shot self with pistol

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 11/25/47

+

7291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G57291

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 44 E Churchill
(c) Hospital or institution: 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 44 E. Churchill St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Patterson
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/21/1881
8. AGE: Years 66 Months 10 Days 2 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name David Patterson
13. Birthplace Md

MOTHER
14. Maiden Name Mary Brodie
15. Birthplace Md

16 (a) Informant Bertha Patterson
(b) Address 44 E Churchill St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/ /47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co. Md

18 (a) Funeral director Isaiah L Brown
(b) Address 108 N Monroe St

19 (a) NOV 25 1947 (Date received by registrar) (b) [illegible]

correct age is especially important. Registrar.

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/ 1947, at 12 P M 45

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to Nov. 23 1947 and that I last saw him alive on Nov. 22 1947.

Immediate cause of death: Chr. Cardio-Renal Disease — Duration: about 2 mo.
Due to
Due to Unknown
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John W. Haines M. D.
Address 502 W. Hamburg St Date signed 11/24/47

292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G57292 3691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 Calhoun St.
(c) Hospital or institution: 16-
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) over 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Calhoun St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	married

6 (b) Name of husband or wife Joseph Brown

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Nov 4 1899

8. AGE: Years	Months	Days	If less than one day
48	—	—	____ hr. ____ min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business Own home

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Joseph Brown
(b) Address 1104 Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location md

18 (a) Funeral director George D. Kelson
(b) Address 1203 Presstman St.

NOV 25 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1947 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1947 to 11-24 1947 and that I last saw her alive on 11-24 1947

Immediate cause of death	Duration
Cerebral hemorrhage	10 Minutes
Due to Hypertension and arterio Sclerosis	unknown
Due to	
Other Conditions Indefinite	24 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. A. Saunders M. D.
Address 1029 N. Stricker St. Date signed 11-25-47

correct age is especially important.

VS 150

83a

2293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G57293
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Road.
(c) Hospital or institution:
27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4702- Harford Road.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MARY HAGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10, 1877

8. AGE: Years 70 | Months 10 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Savoy, New York
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Lawrence O'Connor
13. Birthplace New York

MOTHER
14. Maiden Name Margt Burns
15. Birthplace New York

16 (a) Informant Mary Isaacs
(b) Address 208 Valley Rd, Lutherville

17 (a) Burial (b) Date thereof 11-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Boyce A. Farley
(b) Address Fulton Ave & Fayette St.

19 NOV 25 1947 (Date rec'd by registrar) (Signature) for Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1947, at 10.15 A.M.

21. I certify that I took charge of the remains described above, held an insp & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11-24-47

7294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 652294

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3444 Cliftmont Ave
(c) Hospital or institution: No 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3444 Cliftmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flora Milchling

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1947, at 7.45 M

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~.
F	W	

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 1887

8. AGE: Years	Months	Days	If less than one day
60	9	21	hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William King
13. Birthplace New York

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr Frank Milchling
(b) Address 3444 Cliftmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director J J Henderson
(b) Address 301 Kentucky ave

19 (a) NOV 25 1947 (Date rec'd by registrar) (b) Huntington W Virginia Registrar

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W M G Kelbach M.D. Medical Examiner.
Date signed Nov 24 '47

VS 151

94a

57295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 57295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3038 Kenyon Avenue
(c) Hospital or institution: 26-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Kenyon Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie L. Rose (MINNIE LOUISE ROSE)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1867

8. AGE: Years 79 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired - Nurse

11. Industry or business

FATHER
12. Name Charles H. Rose
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Ammer
15. Birthplace Germany

16 (a) Informant Mrs. Arthur Reinheimer
(b) Address 8 W. Burke Avenue - 4

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 NOV 25 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22/47 19 at 1:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 11/23/47

57296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. 57296

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton + Wilkens Ave

(c) Hospital or institution: St. Agnes Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 603 N. Chas. St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Edith M. Lette.

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23 - 1901

8. AGE: Years	Months	Days	If less than one day
46	9	1	hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation House wife.

11. Industry or business

FATHER

12. Name Marcellus Zimmerman

13. Birthplace W. Va.

MOTHER

14. Maiden Name Sarah Chockley.

15. Birthplace W. Va.

16 (a) Informant Jacqueline V. Bowman

(b) Address 603 N. Charles St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 26 1947 (month) (day) (year)

(c) Cemetery or crematory White Sulphur Springs W. Va.

Location

18 (a) Funeral director Roth & B. M. Walter

(b) Address Platt, Stucker Bldg

19 Nov 25 1947 (b) Date rec'd by registrar Lexington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1947, at 9.50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19.

and that I last saw h alive on 11/24 1947.

Immediate cause of death	Duration
Uremia	
Due to Hydronephrosis	
Due to Carcinoma of cervix.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide at M

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. McL Wallace M. D.

Address 7 E. Lexington Date signed 11/25/47

X

CORRECT AGE is especially important

7297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 657297

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution: 12-2
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Barclay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Powell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Howard Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years: 40 | Months | Days | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Harrison
13. Birthplace Maryland

MOTHER
14. Maiden Name Liliana Francis
15. Birthplace Maryland

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Joseph S. Lockard
(b) Address 1304 N. Central Ave

19 NOV 25 1947 (Date rec'd by registrar) (b) Huntingtown for Nathaniel, Md. Registrar

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1947 at 10:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1947 to Nov. 22 1947 and that I last saw h[illegible] alive on 19

Immediate cause of death Uremia — Duration: 4 months

Due to Arteriosclerotic nephritis

Due to

Other Conditions R-S hypertension cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Grob M. D.
Address J N H Date signed 22 Nov 47

VS 150

X

57298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 57298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1215 W Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 W Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Richard Norris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1895.

8. AGE: Years 52 | Months 5 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick Morgan
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Eliza Smith
15. Birthplace Washington, D.C.

16 (a) Informant Richard Norris
(b) Address 1215 W. Lexington St.

17 (a) Burial (b) Date thereof Nov. 26 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3244 Schroeder St.

19 (a) NOV 25 1947 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21 1947, at 7:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to hen death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Lubawski M.D.
Medical Examiner.
Date signed 11/26/47

657299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 657299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1040 - Penna Ave
(c) Hospital or institution: 17 - 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) unk

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1040 - Penna Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delia Feeney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife unk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1901

8. AGE: Years 45 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace unk (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Unknown
13. Birthplace

MOTHER: 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant William Comish
(b) Address 1032 N. Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25, 1947 (month) (day) (year)
(c) Cemetery or crematory Nat. Arbutus
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 320 N. Schroeder St

19 (a) NOV 25 1947 (Date rec'd by registrar) (b) Arlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21 1947 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1947 to 11/21 1947 and that I last saw h alive on 10/11 1947.

Immediate cause of death: Chronic Cardiac Vascular Renal Disease — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Jacquin M. D.
Address 1200 Arlington Ave Date signed 11/24/47

correct age is especially important. Physicians, please

VS 150

57300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 057300

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 E. Cold Spring Lane
(c) Hospital or institution: 27-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 East Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabella Agnes Patrick

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Joseph E. Patrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1871

8. AGE: Years	Months	Days	If less than one day
75	11	0	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Magness
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Francis X. Patrick
(b) Address 526 E. Cold Spring Lane

17 (a) Burial (b) Date thereof 11-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) NOV 25 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22nd, 1947, at 6 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1947 to Nov. 22 1947, and that I last saw her alive on Nov. 22 1947.

Immediate cause of death (Bronchopneumonia) — Duration 4 days
Due to
Due to
Other Conditions Suppurative Parotitis Left; Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilbur H. Fleming M. D.
Address 11 E. Chase St. Date signed 11-25-47

Correct age is especially important if under 1 day

VS 190

X.

G57301 NICKENS ✓ G57301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G57301

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2325 Madison Ave
(c) Hospital or institution: 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Linna Nickens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Rev. John Amos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1889

8. AGE: Years 58 | Months 2 | Days 23 | If less than one day: hr. min.

9. Birthplace Northumberland Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Eli Higgins

13. Birthplace Northumberland Co. Va.

MOTHER: 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. Elvira Campbell

(b) Address 2325 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Northumberland Co. Va.

18 (a) Funeral director Mrs. Lavery A. Holland

(b) Address 1631 West Mill Ave

19 NOV 25 1947 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1947, at 7.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1947 to Nov 23 1947 and that I last saw her alive on Nov 22 1947.

Immediate cause of death	Duration
Carcinomatosis	6 weeks
Due to Carcinoma of Ovary	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

Autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eli Gordon Higgins M. D.

Address 5043 Madison Ave Date signed Nov 24

X 11/26/47

7302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

657302 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Levine Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Herman I.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1879

8. AGE: Years 68 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Levine
13. Birthplace Russia

MOTHER
14. Maiden Name Mary Epstein
15. Birthplace Russia

16 (a) Informant Miss Helen Cohen
(b) Address 1429 Bolton Street

17 (a) Removal (b) Date thereof 11/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew
Location Norfolk, Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) NOV 25 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25 1947, at 9:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection and Ing. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation by illuminating gas.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-25-47 at 8:30 A.M.
(b) Where did injury occur? 1429 Bolton St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury One open burner gas heater

23. Signature George G. Merrill M.D.
Medical Examiner
Date signed 11/25/47

7303

BALTIMORE CITY HEALTH DEPARTMENT ✓ 92B Registered No. 057303

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4212 Groveland Ave.
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4212 Groveland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIAN RACHEL POTEET

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John Wilmer Poteet Sr.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 11, 1872

8. AGE: Years	Months	Days	If less than one day
75	9	13	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Daniel Powell
13. Birthplace Wales

MOTHER
14. Maiden Name Virginia K. Jenkins
15. Birthplace Balto., Co., Md.

16 (a) Informant Mr. John W. Poteet Jr.
(b) Address 5608 Stonington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director WM. H. TICKNER &SONS INC.
(b) Address North & Pa. Aves., Balto., Md.

19 (a) Filed by (Registrar) NOV 29 1947 (b) Huntington Williams, M.D. Registrar

V S 190

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1947, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1944, to Nov. 24 1947, and that I last saw her alive on Nov. 1 1947

Immediate cause of death	Duration
Acute Cardiac Failure } Pulmonary Edema	Few hours
Due to Chronic Mitral Incompetency	4-5 yrs.
Due to Cerebral Sclerosis	4-5 yrs.
Other Conditions Hemiplegia 1944	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry O. Kelly M. D.
Address 250 W. Pa. Ave Date signed 11-25-47

X

57304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 657304

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 Pennsylvania Ave
(c) Hospital or institution: 14-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town write RURAL and give town)
(d) Street No. 2218 Etting St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George O Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Estelle Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-11-1899

8. AGE: Years 48 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Elisha B. Scott

13. Birthplace Maryland

MOTHER 14. Maiden Name Harriett Edwards

15. Birthplace Maryland

16 (a) Informant Estelle Scott

(b) Address 2218 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-47 (month) (day) (year)

(c) Cemetery or cemetary Arlington Cemetary

Location Md

18 (a) Funeral director Wm H. Jackson

(b) Address 916 Penna Ave

19 NOV 25 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1947, at 4:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William F. Helfrich M.D. (Medical Examiner)

Date signed Nov 23, 1947

VS 181

57305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. 657305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 924 Argyle Ave.
(c) Hospital or institution: 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Argyle Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-11-2691

4. Sex: Male

5. Color or race: C.

6 (a) Single, married, widowed, or divorced: Widwed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John R. Thompson
13. Birthplace md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Hilda Covington
(b) Address 924 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-47 (month) (day) (year)
(c) Cemetery or crematory
Location St. Peters Cem.

18 (a) Funeral director Logan & Hale
(b) Address 1047 N. Fulton Avenue

19 (a) Nov 26 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1947, at 4.0 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10-47 1947 to 11-23- 1947 and that I last saw h. 1me alive on 11-23 1947

Immediate cause of death: Aortic Heart Disease — Duration: 1

Due to indefinite

Due to

Other Conditions Myocardial Failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Wendler M. D.
Address 841 Hamburg Date signed 11-24-47

correct age is especially important. Physicians, please

G57306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G57306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2539 Greenmount Ave
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2539 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAISEY DAVIS SMT.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
f	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1884

8. AGE: Years	Months	Days	If less than one day
62 63 SMT.	11	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Joseph Griffith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dora Syles
15. Birthplace Baltimore Md.

16 (a) Informant Rubin G. Davis
(b) Address 25-39 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26 1947 (Month) (day) (year)
(c) Cemetery or crematory Woodland Cem
Location Baltimore Md

18 (a) Funeral director John C. Moran
(b) Address 3602 Baltimore St

19 (a) NOV 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/47 19..., at 1:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 11/24/47

57307 GM. 46532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH .13B

✓ G57307 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Park Heights & Woodland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Ganley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20 - 1900

8. AGE: Years	Months	Days	If less than one day
47	-	3	hr. min.

9. Birthplace Balto. MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael (B) Ganley
13. Birthplace Balto.

MOTHER
14. Maiden Name Annah Dunn (B)
15. Birthplace Balto. MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 NOV 25 1947 (Date filed by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 - 1947, 7.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July - 14 1939, to Nov. 23 - 1947, and that I last saw him alive on Nov. 23 - 1947

Immediate cause of death	Duration
Leukemia Acute	
Due to	
Due to	
Other Conditions Pulmonary Tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dr alone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Robinson Jr M. D.
Address Balt City Hosp Date signed 11/29/47

Correct age is especially important

V S 150

1242

57308 GM. 115382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 057308

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3338 W. Belvedere Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Linden Bowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Dora L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26. 1884

8. AGE: Years	Months	Days	If less than one day
(65) 62	10	28	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation Retired Operator
11. Industry or business Balto Transit

FATHER
12. Name Albert Bowman
13. Birthplace MD.

MOTHER
14. Maiden Name Mary Wayne
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)
(c) Cemetery or crematory Rock Run
Location Harford Co. Md.

18 (a) Funeral director Lyons Bros
(b) Address 505 W. Fayette Ave.

19 (a) NOV 25 1947 (Date rec'd by registrar) (b) Registrar

Correct age if calculated from birthdate given.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 - 1947, at 5.20PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 - 1947, to Nov. 23 - 1947, and that I last saw him alive on Nov. 23 - 1947

Immediate cause of death Hemiplegia (a) Duration
(b) Uremia

Due to Hypertensive & Arterio-sclerotic C-V Disease.

Due to

Other Conditions Hemiplegia, Ct. Bronchopneumonia.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert R. Faber M. D.
Address Balto City Hosps Date signed 11-23-47

X

7309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c ✓

Registered No. 657309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 253 S Madeira
(c) Hospital or institution: 25

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 253 S Madeira St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie C. P. Ullrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John Ullrich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5 1869

8. AGE: Years	Months	Days	If less than one day
78	-	19	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Chas Schumacher
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea
15. Birthplace Germany

16 (a) Informant Mrs Clinton Hutchinson
(b) Address 253 S Madeira St

17 (a) Burial (b) Date thereof Nov 28
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 NOV 25 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1947, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1925 to Nov. 24 1947 and that I last saw her alive on Nov. 22 1947

Immediate cause of death	Duration
Myocardial insufficiency	3 wks
Due to Chronic myocarditis	10 yrs.
Due to Chronic arteritis	35 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Sappenfield M. D.
Address 1302 Eastern Ave Date signed 11-24-47

X

57310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G57310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117-Upnor Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLOYD E. RUSH

3 (b) If veteran, name war: War I

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Irene B. Rush

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Sept 3 1896

8. AGE: Years	Months	Days	If less than one day
51	2	21	hr. min.

9. Birthplace Accident, Md.
(Town, county, and state)

10. Usual Occupation Hotel Mgr.

11. Industry or business

FATHER
12. Name Martin S. Rush
13. Birthplace Md.

MOTHER
14. Maiden Name Leona Forsyth
15. Birthplace Md.

16 (a) Informant Victor J. Miller Son
(b) Address 109-Northwood Ave Spring, Md

17 (a) Entombment (b) Date thereof 11 26 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director John J. McDonald & Son
(b) Address 1900 Eutaw Place

NOV (a) [illegible] 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150 [illegible]

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1947, at 1:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1947, to Nov. 24 1947, and that I last saw HIM alive on Nov. 24 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension, Essential	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Sat - Described Report Negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 11-24 M. D.

X

57311 BALTIMORE CITY HEALTH DEPARTMENT 4 746 Registered No. 057311

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Green St.
(c) Hospital or institution: Univ. of Md. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbott
(c) City or town Trappe
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nora Gannon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	M.

6 (b) Name of husband or wife Wm. B. Gannon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Talbot Co. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Samuel Lynch
13. Birthplace Md

MOTHER 14. Maiden Name Martha DeFord
15. Birthplace Md

16 (a) Informant R. Ellis Clark
(b) Address Easton - Md.

17 (a) Burial (b) Date thereof 11-28-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton Md

18 (a) Funeral director R. Ellis Clark
(b) Address Easton Md

NOV 25 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1947, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1947 to 11/25 1947, and that I last saw her alive on 11/25 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Abdominal Carcinoma	
Secondary Anemia	
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Hyperkeratosis of Esophagus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. J. Phillips M. D.
Address Univ. Hosp. Date signed 11/25/47

X

57312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 72a

Registered No. 57312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Wicomico
(c) City or town Hebron
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Maggie Kellam
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William
6 (c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
64			....hr. ....min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Warfield
13. Birthplace Va

MOTHER
14. Maiden Name Susan Gray
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 11/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Hebron Cem.
Location Hebron, Md
18 (a) Funeral director David K. Messick
(b) Address Hebron, Md.
19 (a) Huntington Williams M.D.
(Signature of local registrar) Registrar
NOV 28 1947

VS 150

correct age is especially important for statistical purposes

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1947, at 9 34/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1947 to Nov 25 1947 and that I last saw h[illegible] alive on Nov 25 1947.

Immediate cause of death	Duration
Intracranial hemorrhage	
Due to Thrombocytopenic purpura	
Due to Aplastic anemia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation.....
of autopsy: Subarachnoid hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Truman D. Stephens M.D.
Address Johns Hopkins Hosp Date signed 11/25/47

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 57313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 Bayard Street
(c) Hospital or institution: 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Bayard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna May Franke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1903

8. AGE: Years	Months	Days	If less than one day
43	11	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Revere Brass & Copper Co.

FATHER
12. Name Frederick William Franke
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Minnie Nolte
15. Birthplace Baltimore, Maryland

16 (a) Informant Frederick W. Franke
(b) Address 915 Bayard Street

17 (a) burial (b) Date thereof 11/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Stree t

19 NOV 26 1947 (Date rec'd by registrar) Washington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1947, at 12:25 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1946 to Nov 24 1947, and that I last saw h[illegible] alive on Nov 24 1947.

Immediate cause of death	Duration
Respiratory failure from upper spinal cord compression	5 hrs
Due to Metastatic carcinoma 2nd & 3rd cervical vertebrae	4 wks
Due to Carcinoma left breast	1 1/2 years
Other Conditions Metastasis to 12th thoracic vertebra	

(Include pregnancy within 3 months of death)

Date of operation Nov 11, 1946

Major findings of operation: Carcinoma left breast, metastases to cervical

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sullivan B. Sullivan M. D.
Address 1114 St Paul St Date signed 11-25-47

VS 150

7814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 057314

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 N. Liberty St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALBERT M. PIERROTT

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-14-5816

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Mary A. Pierrott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6th 1879

8. AGE: Years	Months	Days	If less than one day
68	3	18	hr. min.

9. Birthplace Phila Pa. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name (Unknown) Pierrott
13. Birthplace France

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mary Blair Pierrott
(b) Address 617 St. Johns Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/47 (month) (day) (year)
(c) Cemetery or crematory Loudown
Location Woodlawn Md

18 (a) Funeral director Wilson & Sons
(b) Address 617 St. John's Rd.

19 NOV 26 1947 (Date rec'd by registrar) Huntington for Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1947, at 4.30 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

~~Due to~~ Hypertrophy of prostate

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur ~~at~~ home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11-24-47

657315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

657315 Registered No.

PLACE OF DEATH:

a) Baltimore City, Maryland

b) Street address 2426 Arunah Avenue

c) Hospital or institution: home 16-5

d) Length of stay in hospital or inst. (yrs., mos., or days)

e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2426 Arunah Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

1. (a) FULL NAME Margaret Ellen Neal

(b) If veteran, name war: no

3 (c) Social Security Account No. -

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

(b) Name of husband or wife: William H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1860

8. AGE: Years 87 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace: Port Deposit, Md.
(Town, county, and state)

10. Usual Occupation -

11. Industry or business -

FATHER 12. Name A. Hall

13. Birthplace Port Deposit, Md.

MOTHER 14. Maiden Name Elizabeth

15. Birthplace Port Deposit, Md.

16 (a) Informant Mr. Frank H. Neal

(b) Address 2426 Arunah Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28-47 (month) (day) (year)

(c) Cemetery or crematory Loudenslager Cemetery

Location Port Deposit, Md.

18 (a) Funeral director Wm. Cook, Inc.

(b) Address 1217 St. Paul Street

NOV 26 1947 Date rec'd by registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 - 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1947, to Nov 24 1947, and that I last saw h[illegible] alive on Nov 23 1947.

Immediate cause of death: Pulmonary Oedema — Duration 24 hrs.

Due to: Arteriosclerosis

Due to: -

Other Conditions: -

(Include pregnancy within 3 months of death)

Date of operation: -

Major findings of operation: -

of autopsy: -

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence - at - M

(c) Where did injury occur? - (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? no (Specify type of place) While at work? -

(e) Means of injury -

23. Signature Bernard J. French M.D.

Address 2329 Arunah Ave. Date signed 11/25/47

7316 2nd slip

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G57316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2307 E. Lafayette Avenue
(c) Hospital or institution: 8-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 E. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles D. Blake

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Clemma I. Blake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1862

8. AGE: Years	Months	Days	If less than one day
85	9	1	hr. min.

9. Birthplace Mathews County, Virginia
(Town, county, and state)
10. Usual Occupation Gate Keeper
11. Industry or business Green Mount Cemetery

FATHER
12. Name Jake Blake
13. Birthplace Virginia

MOTHER
14. Maiden Name Mattie
15. Birthplace Virginia

16 (a) Informant Mrs. Robertine B. Smith
(b) Address 2307 E. Lafayette Avenue

17 (a) burial (b) Date thereof 11/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 NOV 26 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1947, at 12:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Nov 25 1947, and that I last saw h[illegible] alive on Nov 24 1947 9 P.M.

Immediate cause of death	Duration
Cardio Respiratory failure	15 Hrs.
Due to Hemiplegia Right side	1 mo
Due to Arterio Sclerosis progressive	years?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. V. Cliffe
Address 5010 Greenleaf Road Date signed 11-25-47
M. D.

X

317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 657317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 E. Lafayette Ave.
(c) Hospital or institution: home

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 E. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Matilda Maxwell Brownback

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: -

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Walton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1853

8. AGE: Years 94 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation no
11. Industry or business -

MOTHER / FATHER
12. Name Samuel Maxwell
13. Birthplace Baltimore

MOTHER
14. Maiden Name Eliza Seward
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. John R. Warde
(b) Address 1706 E. Lafayette Ave.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Nov. 28-47 (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem. Baltimore Md.
Location Greenmount

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 26 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 19 47, at 11:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1947 to Nov 24 19 47 and that I last saw h Er alive on Nov 24 19 47.

Immediate cause of death: Coronary Occlusion — Duration 11/4/47
Due to: Generalized Arterio-
Due to: Sclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter F Stange M.D.
Address 207 E. Centre St Date signed 11/25/47

X

518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 179X

✓ 657318 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Sinai Hospital 27-20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3713 Clarks Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Rovner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Hyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name
13. Birthplace Russia

MOTHER 14. Maiden Name
15. Birthplace Russia

16 (a) Informant Maurice Rovner
(b) Address 4304 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location Berman Hill Road.

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-1126 W. North Avenue

NOV 26 1947

(c) Date received by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1947, at 7 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Methyl salicylate poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/24/47 at 3713 Clarks Lane M.
(b) Where did injury occur? Baltimore City
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of Poison

Signature Emil J. Rovner M.D.
Medical Examiner.
Date signed 11-25-47

X 121

319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

Registered No. 657319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 275 N. Exeter St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 275 N. Exeter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15-1901

8. AGE: Years 45 46 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Wearington N.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Anthony Terry
13. Birthplace Wearington N.C.

MOTHER
14. Maiden Name Mary Balthrop
15. Birthplace Wearington N.C.

16 (a) Informant Annie Powell
(b) Address 5802 Bellgrove Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley ave

19 NOV 26 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

Correct age if especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1947 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1947 to Nov 24 1947 and that I last saw h alive on Nov 24 1947

Immediate cause of death	Duration
Carcinoma of uterus	9 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwood Jones M. D.
Address 5354 Dolfield Date signed Nov 26 47

VS 150

320 CM.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 657520

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Years
(e) Length of stay in Baltimore (yrs., mos., or days) 80 80 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Knoop

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Elizabeth (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April -21 -1859

8. AGE: Years	Months	Days	If less than one day
88	6	18	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name August Knoop
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Lane
15 Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 25 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 26 1947 (Date filed by Registrar) (b) Registrar

V S 150

correct age is especially important. Information

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 - 1947, at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6-40 1940 to Nov. 9 - 1947 and that I last saw him alive on Nov. 9- 1947

Immediate cause of death	Duration
Carcinoma Rectum	1 month
Due to Hypertension	
Carcinoma Uterus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Patterson Jr. M. D.
Address Balt. City Hosp. Date signed 11-26-47

X

7321 AB-40891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

657321 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 33yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 S. Bethel Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Brittinham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May ? 1883

8. AGE: Years	Months	Days	If less than one day
64	6		hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Odd jobs - Housewife

11. Industry or business

FATHER 12. Name John Henry Burmingham

13. Birthplace Maryland

MOTHER 14. Maiden Name Sabar Savage

15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School NOV 25 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 26 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH November 12 19 47, at 3.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12- 19 30 to 11-12- 19 47, and that I last saw h er alive on 11-12- 19 47

Immediate cause of death: Pulmonary Edema — Duration: Days

Due to: Cardiac Insufficiency — weeks

Due to: Hypertension - Arteriosclerotic Cardiovascular Disease. — years

Other Conditions: Calcification of Kidneys, Traumatic Arthritis of Knee.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee P

Address Baltimore City Hosp Date signed 11-20-47 M. D.

V S 150

correct age is especially important. A typewriter or pen should be used in completing this certificate.

322
AB-37286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. 053322

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Matilda Carrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31- 1855

8. AGE: Years	Months	Days	If less than one day
92	9	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Hooker
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ann Welch
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 25 1947

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 26 1947 (b)
(Date rec'd by registrar)

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22- 1938, to 11-15 1947, and that I last saw h er alive on 11-15 1947.

Immediate cause of death	Duration
Senile Dementia	
Due to Cerebral Arteriosclerosis	
Due to Generalized Arterio-sclerosis	
Other Conditions Pyelitis, Bedsore-Critical, Gen. Debilitation	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 11-20-47

97

Correct age is 93

57323 BC A-9353

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 159

Registered No. G57323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 31 (If outside city or town limits, write RURAL and name town)
(d) Street No. 2106 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pamela Jean Marie Marra

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Wh | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 7 47

8. AGE: Years: 0 | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jos. W. Marra
13. Birthplace Charlottesville - Va.

MOTHER
14. Maiden Name Laura Mae Harlow
15. Birthplace Charlottesville - Va

16 (a) Informant Laura Mae Marra
(b) Address 2106 Orleans St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 26 1947 (Date rec'd by registrar) (c) Signature for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1947 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1947 to Nov. 9 1947, and that I last saw her alive on Nov. 9 1947.

Immediate cause of death | Duration
Due to Atelectasis
Due to Prematurity.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Davis M.D.
Address Sinai Hosp. Date signed 11/24/47

correct age is especially important

VS 3

7324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1611 c

Registered No. G57324

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 Monument St
(c) Hospital or institution: Sinai 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto-31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Weisenan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Wht

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 6 47

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Balto-Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence N. Weisenan
13. Birthplace Penna

MOTHER
14. Maiden Name Va. H. Taylor
15. Birthplace Va.

16 (a) Informant Virginia G. Taylor
(b) Address 127 N. Wolfe St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School NOV 24 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 26 1947 (Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1947, at 12:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1947 to Nov. 9 1947, and that I last saw him alive on Nov. 9 1947.

Immediate cause of death Pulmonary edema & congestion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pulm. edema & congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sydney Garcia M. D.
Address Sinai Hosp. Date signed 11/24/47

Correct age if deceased is under 1 year

7325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 657325

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4135 Forest Park Ave.
(c) Hospital or institution:
none

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4135 Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Richard L. Shipley, D. D.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Cora Belle Roberts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1879

8. AGE: Years 68 | Months 5 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Anne Arundel County, Md.
(Town, county, and state)

10. Usual Occupation clergyman

11. Industry or business M. E. Baltimore Methodist Church

FATHER
12. Name Theodore Shipley
13. Birthplace Anne Arundel Co., Md.

MOTHER
14. Maiden Name Cecilia Shipley
15. Birthplace Anne Arundel Co., Md.

16 (a) Informant Mrs. Cora R. Shipley
(b) Address 4135 Forest Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1806 Eutaw Place

NOV 26 1947 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

correct age is especially important. Physicians, please give

MEDICAL CERTIFICATION

20. DATE OF DEATH November (24) 25 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1947, to 11-25 1947, and that I last saw h[illegible] alive on 11-25 1947.

Immediate cause of death ... Duration

Central hemorrhage — 1 day

Due to Cerebral Embolism — —

Due to ...

Other Conditions ...

(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

... of autopsy: ...

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ...
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work?
(Specify type of place)
(e) Means of injury ...

23. Signature Harry W. Warren M. D.

Address 2604 Garrison Blvd. Date signed 11-26-47

X

326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 657326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 W. HAMBURG ST.
(c) Hospital or institution: 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 W. HAMBURG ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN C. REHMERT

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No.	212-10-6791	MALE	WHITE	MARRIED.

6 (b) Name of husband or wife ELIZABETH T.
6 (c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) JULY 4, 1885

8. AGE: Years	Months	Days	If less than one day
62	4	20	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation BAKER
11. Industry or business ROASTERS

FATHER
12. Name CHARLES RENMERT
13. Birthplace GERMANY

MOTHER
14. Maiden Name CAROLINE WISE
15. Birthplace UNKNOWN

16 (a) Informant ELIZABETH T. RENMERT
(b) Address 1114 W. HAMBURG ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-26-47 (month) (day) (year)
(c) Cemetery or crematory BALTO. CEM.
Location NORTH AVE.

18 (a) Funeral director Joseph T. Cambone, Jr.
(b) Address 418 N. Grand Ave. Balto. 17
NOV 26 1947 Huntington Williams M.D.
(Date received by registrar)

VS 150

correct age is especially important. Physicians please

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1947, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1947 to 11/24 1947 and that I last saw h[illegible] alive on 11/24 1947

Immediate cause of death: Acute Cardiac Failure — Duration: 1 da

Due to: Cerebro Vascular Renal Disease — 1 yr

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Joseph L. Landecker
Address 67 E Washington Blvd signed 11/26/47 M. D.

X

227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. 657227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Tampa
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 E. Emiley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Tinsley THELMA LOUISE TINSLEY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Wm. Thomas Tinsley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-18-21

8. AGE: Years	Months	Days	If less than one day
26	8	7	hr. min.

9. Birthplace Fla Tampa
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER 12. Name Emmett C. Clark
13. Birthplace Ga

MOTHER 14. Maiden Name Minta M Pollard
15. Birthplace Fla

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/26/47 (month) (day) (year)
(c) Cemetery ~~Tampa~~ Garden of Memories
Location Tampa, Fla.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 NOV 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

correct age is especially important

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1947, at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1947 to Nov. 25 1947 and that I last saw her alive on Nov. 25 1947

Immediate cause of death: Subacute bacterial endocarditis — Duration: 5 mos.
Due to: B. pyocyaneus
Due to: pelvic aneurysm
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: vegetations on aortic valve, splenomegaly
of autopsy: pelvic aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Sisson M. D.
Address Johns Hopkins Hosp. Date signed Dec 5 1947

328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 657328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 159
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4121 Fairview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EVA SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Williaqe

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Bernard Smith

(b) Address 4121 Fairview ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-47 (month) (day) (year)

(c) Cemetery or crematory Herring Run

Location Bowley Lane

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

NOV 26 1947 (Date rec'd) (b) Huntington Williams, M.D. Registrar

correct age is especially important. Typewriter preferred.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1947 at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1947 to 11/25 1947 and that I last saw her alive on 11/25 1947

Immediate cause of death CARCINOMA of PANCREAS with METASTASES to the BRAIN — Duration

Due to HYPERTENSIVE CARDIO VASCULAR DISEASE

Due to 2 CONGESTIVE FAILURE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Sparma M.D.
Address Sinai Hospital Date signed 11/26/47

X

7329 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 653329

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rogers Ave
(c) Hospital or institution: West Baltimore Jail Hosp 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Bareleg St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob M Goodman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Anna Goodman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Harry
13. Birthplace Russia

MOTHER 14. Maiden Name Fannye
15. Birthplace Russia

16 (a) Informant Anna Goodman
(b) Address 1106 Bareley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Rogers Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 206 Eutaw Place

NOV 26 1947 Hortense Williams (Date rec'd) (Registrar)

VS 150

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1947, at 10:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1947 to 11-24 1947 and that I last saw h.im alive on 11-24 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Emphysema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Berdinsky M. D.
Address West Balto Jail Hosp Date signed 11/24/47

57330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

657330 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 Garrison Boulevard
(c) Hospital or institution: 15-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Garrison Boulevard (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Blum Goldstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Bernard
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta
15. Birthplace Russia

16 (a) Informant Morris Goldstein
(b) Address 3602 Garrison Boulevard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-47 (month) (day) (year)
(c) Cemetery or crematory
Location Baltimore Hebrew

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Gaetano Place

19 NOV 26 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

correct age is especially important. Expressed in years

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25-1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to 25 Sept. 1947, and that I last saw h[illegible] alive on Sept 25 1947

Immediate cause of death	Duration
Pulmonary edema	6 hours
Due to Cardiac insufficiency	2 days
Due to	
Other Conditions Carcinoma of colon c metastases (Include pregnancy within 3 months of death)	7
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Weiman M.D.
Address 3900 Dorchester Rd Date signed 26 Nov 47 M. D.

95c

331

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 559

Registered No. 657331

2. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 193 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8222 Liberty Heights Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Edward Wood

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1874

8. AGE: Years	Months	Days	If less than one day
73	1	12	hr. min.

9. Birthplace Anne Arundel Co. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Nov 27 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director Benjamin H. Dorsey
(b) Address 1615-17 Pennsylvania Ave.

19 NOV 26 1947 Huntington Williams M.D.
(Date received by registrar) (Registrar)

V S 130

correct age is especially important. Typewriter preferred.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1947, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to Nov. 24 1947, and that I last saw him alive on Nov. 24 1947.

Immediate cause of death	Duration
Squamous cell carcinoma of antrum	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 11/26/47

X

1332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓170c

Registered No. 657332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Pearl Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Sanphillipo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation Fruit Dealer

11. Industry or business

FATHER
12. Name Michael Sanphilipo
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Giglio
15. Birthplace Italy

16 (a) Informant Sarah Sanphilipo
(b) Address 310 N. Pearl Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28. 1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cemetery
Location Old Frederick Rd

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Greenmount Ave

19 NOV 26 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1947, at 6 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Rupture of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-24-47 6:10 P.M. 4/2
(b) Where did injury occur? Baltimore St. and Fremont Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury "Hit by Bus"

23. Signature Carl L. Voss M.D.
Medical Examiner.
Date signed 11/25/47

333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57333
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Caton Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Wilkens Avenue
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John Seifert

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-6113

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida Mary (Stahl)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1881

8. AGE: Years	Months	Days	If less than one day
66	7	8	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Adam. Seifert
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Elis Fuchs
15. Birthplace Md

16 (a) Informant Mrs Ida M Seifert
(b) Address 4203 Wilkens Ave

17 (a) Burial (b) Date thereof Nov. 28 '47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Harry H Wyche
(b) Address 4101 Edmondson Ave Baltimore, Md.

19 NOV 26 1947 (b) Huntington Hollins, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25/47 19 , at 7:06 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Nov 19 47 to 25 Nov 19 47 and that I last saw him alive on 24 Nov 19 47

Immediate cause of death	Duration
Intracranial Hemorrhage	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Intracranial Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James E Hamill M.D.
M. D.
Address St Agnes Hosp. Date signed 25 Nov 47

correct age is especially important. Physicians, please see that it is correctly stated.

VS 150

X

7334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 657334

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2249 Annapolis Rd
(c) Hospital or institution: 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2249 Annapolis Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William H Berger

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-7421

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ or wife: Bessie L (Richardson)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1884

8. AGE: Years 63 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business Charles T Brandt

MOTHER | FATHER
12. Name ? Berger
13. Birthplace Germany
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr Edward R Berger
(b) Address 4026 Walbrook St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26 1947 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location 3801 Frederick Ave

18 (a) Funeral director Henry H Wittle
(b) Address 4101 Edmondson Ave

19 (a) NOV 26 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1947, to Nov 22 1947 and that I last saw ~~him~~ her alive on Nov 22 1947

Immediate cause of death	Duration
carcinoma of stomach, metastatic	unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Rosenau M. D.
Address 206 S. Gilmor St Date signed 11-25-47

· correct age is especially important. ·

7335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G57335

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible] N. Broadway
(c) Hospital or institution: Church Home & Hospital 26-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5219 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Rose - Duda

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Theodore
6 (c) If alive, give age - years
7. Birth date of deceased (mo., day, yr.) Jan. 15, 1863
8. AGE: Years 84 | Months 10 | Days 9 | If less than one day ... hr. ... min.
9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Henri Dragon
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rockmark, Eva
15. Birthplace: Russia

16 (a) Informant: Daughter Rose Urban
(b) Address: 5219 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/47 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart of Mary
Location: German Hill Rd

18 (a) Funeral director: John J Duda
(b) Address: 2829 Hudson St

19 (a) NOV 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS² 150 — 1-48

correct age is especially important. Physicians: please write clearly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 19 47, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 19 47, to 11/24 19 47, and that I last saw her alive on 11/24 19 47.

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Pulmonary Embolism	5
Due to: [illegible]	
Other Conditions: Appendicial abcess.	

(Include pregnancy within 3 months of death)

Date of operation 11/19/47
Major findings of operation: Appendicial abscess, following ruptured appendix
of autopsy: — none —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Johnson M. Cullen M. D.
Address: Church Home & Hosp. Date signed 11-29-47

X

336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G57336 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Lorman St. 15-2
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Lorman St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Jordan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Samuel Jordan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 20, 1887

8. AGE: Years 60 | Months 7 | Days 5 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Eva Stewart
(b) Address 1814 Lorman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location [illegible]

18 (a) Funeral director Geo. D. Pelham
(b) Address 1305 Pressman

NOV 26 1947 (Date rec'd by registrar) (b) Lentington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1947, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1947 to Nov 25 1947 and that I last saw her alive on Nov 25 1947.

	Duration
Immediate cause of death: Cardio Vascular Disease	1 yr.
Due to: Cerebral Hemorrhage	3 days
Due to: Hypertension	1 yr.
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey M.D.
Address 1928 Penna. Ave Date signed 11/26/47

Please write the cause of death clearly and correct age is especially important. Physicians: please write

7337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

657337 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Huntingdon Ave
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.	6 (b) Name of husband or wife	6 (c) If alive, give age
Female	White	Married	Daniel	years

7. Birth date of deceased (mo., day, yr.) Oct 27 1889

8. AGE: Years 58 | Months 8 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Pugciacco
13. Birthplace Italy

MOTHER 14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Daniel Marshall
(b) Address 703 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 28. 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Edward Faulkner
(b) Address 359 Washington Blvd

19 (a) Nov 26 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Nov 1947, at 10:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Nov 1947 to 24 Nov 1947 and that I last saw h[illegible] alive on 24 Nov 1947.

Immediate cause of death Hypostatic Pneumonia — Duration
Due to Hypertension and Cardiovascular Renal disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Proctor M.D.
Address 1123 St Paul St Date signed 25 Nov 1947

657338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

657338 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 213 Ware St
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 W. Ware St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert H. Murray

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife Beatrice Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1- 1911

8. AGE: Years	Months	Days	If less than one day
36	10	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Murray
13. Birthplace Md

MOTHER
14. Maiden Name Hattie Robert
15. Birthplace Md

16 (a) Informant Mrs Beatrice Murray
(b) Address 213 W. Ware St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A-R Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) NOV 26 1947 (b) Data received by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1947, at 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8, 1947, to Nov 22 1947 and that I last saw h.l— alive on Nov 22 1947.

Immediate cause of death Uraemia

Duration
3 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul A. Johnson M.D.
Address 2329 Guilford Date signed Nov. 24 1947.

correct age is especially important. Typewrite or print plainly with pen and ink.

V S 150

G57339 D.C 5715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G57339 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 641 N. Carey St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME SHIRLEY A. BARNES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1946

8. AGE: Years	Months	Days	If less than one day
1	2	7	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name James Barnes.
13. Birthplace Franklin, Va.

MOTHER
14. Maiden Name Lillie Nance
15. Birthplace Lawrence, S. C.

16 (a) Informant Mrs. Lillie Barnes
(b) Address 641 N. Carey St.

17 (a) Burial (b) Date thereof Nov. 26 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location.....

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N Schroeder St.

19 (a).....
(Date rec'd by registrar) Huntington Williams, M.D.

NOV 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1947, at 3 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Carl L. Royer M.D.
Medical Examiner
Date signed 11-24-47

657340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 32a

657340

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green Sts.

(c) Hospital or institution: University Hospital 4-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 655 Vine St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Madeline Williams ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1921

8. AGE: Years	Months	Days	If less than one day
26	4	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name James Williams

13. Birthplace Leachville, Va.

MOTHER 14. Maiden Name Mary Woods

15. Birthplace Laurel Md.

16 (a) Informant Mary Woods

(b) Address 655 Vine St.

17 (a) Burial (b) Date thereof Nov. 28, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1947, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1947, to Nov 24 1947, and that I last saw h[illegible] alive on Nov 24 1947.

Immediate cause of death	Duration
Liver failure	
Due to acute infectious Hepatitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature R. C. Duvall Jr. M. D.

Address Univ. Hosp. Date signed Nov. 25

correct age is especially important. Physicians, please write.

X

CHARLES EDWARD LINDSAY

G57341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G57341

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 W 36th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME Charles Edward Lindsay
3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Margaret Lindsay
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1878

8. AGE: Years 69 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Paper Hanger
11. Industry or business

FATHER: 12. Name George Lindsay
13. Birthplace Maryland

MOTHER: 14. Maiden Name Annie Rogers
15. Birthplace Maryland

16 (a) Informant Hospital record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28-1947 (month, day) (year)
(c) Cemetery or crematory Meadowridge Memorial Park
Location Howard Co. Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 2431 Falls Road
19 (a) (Date rec'd by registrar) (b) Washington Blvd.

NOV 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1947, at 1.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1947 to Nov 25 1947 and that I last saw h.. alive on Nov 25 1947

Immediate cause of death Pulmonary embolus — Duration 5 minutes

Due to Postoperative diabetes — Duration ?

Due to

Other Conditions Arteriosclerosis — Duration 5-6 yrs?

Leak of sutures
(Include pregnancy within 3 months of death)

Date of operation 11-4-47

Major findings of operation: Benign prostatic hypertrophy

of autopsy: Laboratory examination

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C Thomas M. D.
Address Union Memorial Hospital Date signed 11-25-47

Please write plainly. Physicians: please write the causes of death clearly and legibly. Undertakers: please see that correct age is especially important.

VS 150

X

G57342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G57342 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4128 Falls Rd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie D. Barnes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife Richard Barnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23-1874

8. AGE: Years	Months	Days	If less than one day
73	7	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Samuel Dare
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Alban
15. Birthplace Maryland

16 (a) Informant Mrs. Effie E. Gaffner
(b) Address 4128 Falls Road

17 (a) Burial (b) Date thereof Nov. 28-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Dursey Funeral Home
(b) Address 3631 Falls Rd. Baltimore, Md.

19 (a) 6 1947 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1947, at 2:10 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Less death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic sclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Braucher M.D.
Medical Examiner.
Date signed 11-25-47

657343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

657343 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5835 York Road
(c) Hospital or institution: at Home 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltcity
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5835 York Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr George Hemmyngs Hocking

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha R. Hocking
(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) October 8 1865

8. AGE: Years 92 | Months 1 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Frostburg Md.
(Town, county, and state)

10. Usual Occupation Physician
11. Industry or business Medicine

FATHER
12. Name Wm. Hocking
13. Birthplace England

MOTHER
14. Maiden Name Jennifer Bolitho
15. Birthplace England

16 (a) Informant Mrs Martha R. Hocking (wife)
(b) Address 5835 York Road.

17 (a) Burial (b) Date thereof Nov 28 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Alleghany
Location Frostburg Md.

18 (a) Funeral director Stewart & Mowbray Co.
(b) Address 108 W North Ave.

19 (a) (Date rec'd by registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1940 to Nov 25 1947, and that I last saw her alive on Nov 25 1947.

	Duration
Immediate cause of death: Myocardial Degeneration	3 yrs
Due to: Arteriosclerosis	
Due to:	
Other Conditions: Bronchopneumonia — Hernia	3 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vernon A Norwood M. D.
Address Church Home & Hospital Date signed Nov 26 1947

VS 150

Please write correctly. Age is especially important. Physicians: please write the

G57344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 83a

G57344 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST 1st
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N. Poppleton ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country None

3 (a) FULL NAME Robert Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/26/1890

8. AGE: Years 56 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Atlanta Ga. (Town, county, and state)

10. Usual Occupation Shoe maker.

11. Industry or business

FATHER 12. Name Wm Price
13. Birthplace Ga

MOTHER 14. Maiden Name unknown
15. Birthplace unknown.

16 (a) Informant Josephine Price
(b) Address 20 N Poppleton st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/47 (month) (day) (year)
(c) Cemetery or crematory Lincoln Cem.
Location Atlanta Ga.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 922 N Mount St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150
NOV 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 47 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1947, to 11/24 1947 and that I last saw h.[illegible] alive on 11/24 1947.

Immediate cause of death Subarachnoid Hemorrhage — Duration
Due to Arteriosclerosis C-V
Due to disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Garner M.D.
Address 1514 Division ST Date signed 11/24/47

correct age is especially important, if unknown, please state.

G57345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X G57345 / 126

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Park Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bessie LORA La Motte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or ~~wife~~ Robert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20, 1867

8. AGE: Years	Months	Days	If less than one day
80	2	5	hr. min.

9. Birthplace California (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Albert E. Thorndike
13. Birthplace California

MOTHER
14. Maiden Name Mary Page
15. Birthplace Mass

16 (a) Informant Mrs. Geraldine V. Witter
(b) Address 100 Park Drive Catonsville

17 (a) Cremation (b) Date thereof 11-28-47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mont Lincoln
Location

18 (a) Funeral director Easton Sons
(b) Address Catonsville, Md.

19 (a) 28 1947 Washington Williams, Registrar
(Date rec'd by registrar)

VS 15 NOV 26

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1947, at 12:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1947 to 11/25 1947, and that I last saw her alive on 11/25 1947.

Immediate cause of death	Duration
(a) Pulmonary E.V.D.E.	
Due to (b) Myocardial failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/14/47

Major findings of operation: Ch. Ch. Benign Ch. Cholelithiasis

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Mintz M. D.
Address Date signed 11/28/47

X

corrected age is especially important. Typewrite or print plainly with pen and ink.

G57346 BALTIMORE CITY HEALTH DEPARTMENT G52346
Registered No.

CERTIFICATE OF DEATH 174a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3115 Glendale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer L. STOVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29th 1897

8. AGE: Years 49 | Months 10 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Police Officer

FATHER
12. Name Alfred Stover
13. Birthplace -

MOTHER
14. Maiden Name Leanie Schafer
15. Birthplace Md

16 (a) Informant Mrs Anna M. Stover
(b) Address 3115 Glendale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov (month) (day) 1947 (year)
(c) Cemetery or crematory Morelands
Location Taylor Ave

18 (a) Funeral director Leo G. Brooke
(b) Address 1701-03 N. Patterson Park Ave

26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

Correct age is especially important

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1947, at 10 20 AM

21. I certify that I took charge of the remains described above, held an Inspection and Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident Probably ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation by illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27/5

(a) Date of injury 11-25-47 at 2:30 P M. ?
(b) Where did injury occur? 3115 Glendale Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Over an hot gas jet

23. Signature George G. Merrill M.D. (Medical Examiner.)
Date signed 11/25/47

X 128

G57347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G57347 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2526 Fleet street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2526 Fleet Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Beres

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Beres
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep 14 1904

8. AGE: Years 43 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Insurance Agent
11. Industry or business

FATHER
12. Name Stanislaus Beres
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Biedronski
15. Birthplace Poland

16 (a) Informant Mrs Mary Beres
(b) Address 2526 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address [illegible] S. Chester Street

10-26 1947 (Date rec'd by registrar) Huntingtown Williams, M.D. Registrar

MEDICAL CERTIFICATION 830

20. DATE OF DEATH Nov. 23 1947 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/31 1947 to 11/23 1947 and that I last saw h[illegible] alive on 11/22 1947.

Immediate cause of death Pulmonary TBC — Duration 10 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Esther F. Nemkowski M. D.
Address 1076 S. East Date signed 11-24-47

Correct age is especially important. Typewrite or print plainly.

VS 3

G57348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57348

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rochrone Avenue
(c) Hospital or institution: Ardleigh Nursing Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3311 GWYNNS FALLS PKWY.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELSIE SONDERMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1881

8. AGE: Years	Months	Days	If less than one day
66	9	16	hr. min.

9. Birthplace Baltimore City.
(Town, county, and state)
10. Usual Occupation Telephone Operator
11. Industry or business Retired

FATHER
12. Name Phillip Sonderman
13. Birthplace Europe

MOTHER
14. Maiden Name Catherine Koch
15. Birthplace Baltimore, Md.

16 (a) Informant Emma E. Sonderman (sister in law)
(b) Address 3311 Gwynns Falls Pkwy

17 (a) Cremation (b) Date thereof Nov. 28, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fairmount Cemetery
Location North Ave & Fairmount Ave

18 (a) Funeral director Walter Brooke Bradley
(b) Address 1922 W. North Avenue

19 (a) [illegible] (b) Victor Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 November 1947, at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Nov 1947, to 25 Nov 1947, and that I last saw [illegible] alive on 25 Nov 1947

DO NOT SEAL

Immediate cause of death	Duration
Coronary Occlusion	20 MINS.
Due to Arteriosclerotic Heart disease.	5-10 years
Due to Generalized Arteriosclerosis	5-10 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2020 N. Charles St. Date signed 26 Nov 1947

VS 150

To be approved by Med. Exam'r.

7349

BALTIMORE CITY HEALTH DEPARTMENT ✓ 657349

CERTIFICATE OF DEATH 48 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Pk. Hgts. Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leah Kandel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Max Kandel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1864

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Pesanek
13. Birthplace Austria

MOTHER
14. Maiden Name Chia —
15. Birthplace Austria

16 (a) Informant Chia Kandel (Mrs)
(b) Address 4112 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jack Penn Inc
(b) Address 2400-02 Eutaw Place

NOV 26 1947 (Date received by Registrar) Hampton Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1947, at 9 60 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1946 to Nov. 26 1947 and that I last saw h.. alive on Nov. 26 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis of Kidneys	
Due to	
Other Conditions Pyelitis Nephritis Chronic	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Abraham Bolopere M. D.
Address 2028 Eutaw Pl. Date signed 11/26/47

correct age is especially important. Physicians, please write

X

57350 B.C.# A-95640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

✓ 657350 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts
(c) Hospital or institution: FRANKLIN SQ HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2009 E. PRESTON ST. (If outside city or town limits, write RURAL and give town)
(d) Street No. BALTIMORE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY SCHNITKER.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S
6 (b) Name of husband or wife: —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-21-47
8. AGE: Years | Months | Days | If less than one day: 3 hr. 40 min.
9. Birthplace BALTIMORE Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Malvin SCHNITKER
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name MARIE SCHALLER
15. Birthplace BALTIMORE

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 26, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 26 1947 (b) (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

PLEASE WRITE THE CAUSES OF DEATH CLEARLY. Physician: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-1947, at 6 46 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1947, to 11/24 1947, and that I last saw him alive on 11-24 1947.

Immediate cause of death: Respiratory Failure — Duration:
Due to: PREMATURITY.
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(c) Means of injury —

23. Signature Geo Linwell M.D.
Address Franklin Sq Hosp Date signed 11/26/47

7351
B.C.# 4. 94999

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 057351

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ of Md Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Bata Nave de Brave
(If outside city or town limits, write RURAL and give town)
(d) Street No. 667 Otsego St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Bagg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Wh | 6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/18/47

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day: 21 hr. 10 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Reginald Charles Bagg.
13. Birthplace Canada. Naturalized

MOTHER
14. Maiden Name Elizabeth Mc Faddin
15. Birthplace Port Deposit, Md.

16 (a) Informant Mother
(b) Address 667 Otsego St Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School NOV 26 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 26 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1947, at 6'5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1947, to 11-19 1947, and that I last saw her alive on 11-18 1947.

Immediate cause of death	Duration
Prematurity	
Due to Leukemia.	
Due to Hypertension Probable eclampsia	
Other Conditions Prolonged hypertension 5 yrs. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Univ of Md Hosp Date signed 11-19-47

PLEASE WRITE CLEARLY — Physicians: please write correct age is especially important.

7352 C.C.N. 15276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G57352 Registered No. 8317½

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address:
(c) Hospital or institution: Univ. Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 26 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 642 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/23/47

8. AGE: Years 26hrs | Months | Days 1 | If less than one day 26 hrs min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Marion Lee
13. Birthplace Sumter

MOTHER 14. Maiden Name Georgiana McDowell
15. Birthplace Sumter

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 26 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 26 1947 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1947, at 1 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Prematurity

Due to: Unknown cause

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl C Fully M. D.

Address Date signed 11-25-47

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

State Anatomical R-94023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G57353

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1256 E. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Neely

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/17/47

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Roy B. Neely
13. Birthplace Va

MOTHER 14. Maiden Name Jessie Janette Jett
15. Birthplace U. S.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Lo Johns Hopkins Medical Schoo NOV 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 26 1947 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1947 at 4:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17 1947 to 11/20 1947 and that I last saw h alive on 11/20 1947

Immediate cause of death CARDIO - RESPIRATORY FAILURE
Due to ASPIRATION
Due to SEPSIS
Due to PREMATURITY. WT 1700 gm.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Spencer
Address Johns Hopkins Hospital Date signed 11/24/47

correct age is especially important. Physicians, please write

354

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 657354 Registered No.

CERTIFICATE OF DEATH 30F

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Herbert
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/21/47

8. AGE: Years	Months	Days	If less than one day
		X	18 hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wayne Herbert
13. Birthplace

MOTHER
14. Maiden Name Dorothy
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo NOV 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 26 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1947 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1947, to Nov 22 1947, and that I last saw her alive on Nov. 22 1947

Immediate cause of death Prematurity — Duration 2 days
Due to Congenital Lues
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Neil Lipsanter M. D.
Address Johns Hopkins Hosp Date signed 11-25-47

correct age is especially important. Physicians: please write plainly.

VS 190

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G57355 ✓ G57355 Registered No.

G57355

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1282 Battery Ave
(c) Hospital or institution: 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 N. Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph F. Bache

3 (b) If veteran, name war W | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife Marguerite Bache | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1 1877

8. AGE: Years 70 | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Aug. 1, 1877 Balto Md (Town, county, and state)

10. Usual Occupation Furniture Business

11. Industry or business

FATHER 12. Name Joseph Bache
13. Birthplace Germany

MOTHER 14. Maiden Name Regina Sommer
15. Birthplace Germany

16 (a) Informant Miss Mary Bache
(b) Address 1282 Battery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 25 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Ritchie Highway

18 (a) Funeral director Francis Edmonds Home
(b) Address 216 S. Charles St.

19. (a) NOV 26 1947 (Date rec'd by registrar) (b) Registrar

Thursday 6:00 Hollander, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 21 1947 to Mar 23 1947 and that I last saw h. alive on Mar 23 1947

Immediate cause of death	Duration
— Acute Dilatation of Heart	1 hr.
Due to — Broncho Pneumonia	2 days
Due to Influenza	8 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D B Wheeler M. D.
Address 1229 Nelson Pl Date signed 11/25/47

X

G57356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G57356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Dolphin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander J. Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	N	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/22/44

8. AGE: Years	Months	Days	If less than one day
3	15	3	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Wheeler
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Savoy
15. Birthplace Md.

16 (a) Informant Sarah Wheeler
(b) Address 704 Dolphin St

17 (a) B (Burial, cremation, or removal) (b) Date thereof 11-28-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1011 N. Arlington Ave

19 (a) (b)
(Signature of person who files and registers death certificate)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1947, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1947 to 11/25 1947, and that I last saw h[illegible] alive on 11/25 1947.

Immediate cause of death Accident

Due to Diabetes Mellitus 5 dys.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5 dys.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant, M.D.
Address 1514 Division Date signed 11/26/47

Correct age is especially important. Physicians: please write plainly.

G57357 — BALTIMORE CITY HEALTH DEPARTMENT — G57357

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: So. Balto. Genr'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore - 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2524 E Oliver St.
(If rural give location)
(e) Citizen of foreign country? No (Name or No)
If yes, name country

3 (a) FULL NAME Mrs Elizabethen Schmatke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Alexander Schmatke
(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Oct 17 [illegible]

8. AGE: Years	Months	Days	If less than 1 day
55	1	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John Bartenfelder
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Muller
15. Birthplace Md

16 (a) Informant Husband
(b) Address same

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-28-47 (month) (day) (year)
(c) Cemetery or crematory Carlwood Cem
Location Taylor Ave
18 (a) Funeral director Jos C Milly Inc
(b) Address 2435 E Oliver St
19 [illegible] rec'd by registrar (Date) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24-1947 at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15-1947 to 11-24-1947 and that I last saw her alive on 11-24-1947.

Immediate cause of death Respiratory failure — Duration Unknown - rate about 5 days
Due to Intracerebral hemorrhage
Due to Hypertensive cardiovascular disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Hillman M.D.
Address South Balto Gen. Date signed 11/29/47

VS 150

Please write the CAUSES OF DEATH — correct age is especially important. Physicians: please write legibly.

G57358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G57358
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belmont & Saratoga Sts
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 E. Joppa Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Warren W. Cameron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ruth Cameron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 70 yrs | Sept 23 1877

8. AGE: Years 70 | Months 1 2 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland (Zion?)
(Town, county, and state)

10. Usual Occupation Education (Retired)

11. Industry or business

FATHER 12. Name Levi Oldham Cameron

13. Birthplace ?

MOTHER 14. Maiden Name Wilson?

15. Birthplace

16 (a) Informant Son

(b) Address 314 E. Joppa Rd

17 (a) Burial (b) Date thereof 11/25/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Tilson Bros
Address 214 E Cont St

NOV 26 1947

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1947, at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1947 to Nov 25 1947, and that I last saw h[illegible] alive on Nov 25 1947.

Immediate cause of death Coronary Thrombosis

Due to Occlusion of Coronary Artery

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Farano M. D.
Address Mercy Hosp Date signed 11/25/47

Please write plainly, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

94a

G57359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G57359
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town (limits, write RURAL and give town)
(d) Street No. 237 N. Fulmore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Meise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ida M Meise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1859

8. AGE: Years	Months	Days	If less than one day
96	9		hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business

FATHER
12. Name Henry Meise
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Myrtle Linwood
(b) Address 1713 N Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director William Ott
(b) Address 1217 St Paul St

19 (a) Filed NOV 26 1947 Huntington Williams, M.D. Registrar
(b) Date by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16/47 19 , at 12:20 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Dawn M.D.
Medical Examiner.
Date signed 11/17/47

VS 151

G57360 D

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G57360 D
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Road
(c) Hospital or institution Reed Hill Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 73 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Rural - Glyndon, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ella McCullough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John J. McCullough

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. , 1874

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Public Maid

11. Industry or business

MOTHER / FATHER

12. Name John Lynch

13. Birthplace Ireland

14. Maiden Name M. Bendy

15. Birthplace Ireland

16 (a) Informant Mrs. Mary Jones

(b) Address Mrs. Mary Jones - 2640

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-47 (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Govans.

18 (a) Funeral director Wiedefeld & Son

(b) Address Greenmount Ave & 22nd

19 NOV 26 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1947, at 10:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23 1947, to Nov. 24 1947, and that I last saw h.er alive on Nov. 23 1947

Immediate cause of death	Duration
Apteria - Sclerotic heart disease and cerebral hemorrhage	
Due to Hypertension Cardio-Vascular Renal	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford N. Kirkpatrick, Jr. M. D.

Address 6 E. Eager Street Date signed 11-25-47

VS 150

PHYSICIANS: Please write plainly. Be sure that the cause of death is correctly stated and that the correct age is especially important. Physicians: please write plainly.

G57361 ✓ G57361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2115 KIRK AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town 2115 KIRK AVE. (If outside city or town limits, write RURAL and give town)
(d) Street No. BALTO., MD. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John PHILLIP Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife ANNIE C. SMITH.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace ALLEGANY Co. CATSKILL, (Town, county, and state)
10. Usual Occupation BUTCHER.
11. Industry or business S-K.

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant MR. EDWARD McELROY
(b) Address 2115 KIRK AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-28-47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location CITY

18 (a) Funeral director WIEDEFELD & SON
(b) Address BRENKMONT & 22ND ST.

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar) NOV 28 1947

VS 19

Correct age if appearing incorrectly

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Nov. 1947, at 4:07 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease.

Due to

Other Conditions Cerebral Vascular Accident 1938
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kanne, Jr. M.D. Medical Examiner.
Date signed 26 Nov. 1947

X

57362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 122B

Registered No. 57362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution:
University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew W Downs

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18 1936

8. AGE: Years	Months	Days	If less than one day
11	7	8	hr. min.

9. Birthplace Jamestown Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Andrew H Downs
13. Birthplace Pikestown Md.

MOTHER
14. Maiden Name Margaret R Jamison
15. Birthplace Abell Md

16 (a) Informant Rosewood School Record
(b) Address Owings Mills

17 (a) Buried (b) Date thereof Nov. 27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosewood
Location Balto. Co.

18 (a) Funeral director J. F. Shue. Sons
(b) Address Pikesville

19 (a) NOV 27 1947 (b) Carlington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1947, at 3:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1947 to Nov 26 1947 and that I last saw h alive on Nov 26 1947.

Immediate cause of death	Duration
Acidosis	
Due to Intestinal Obstruction	
Due to	
Other Conditions Dehydration & Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edw Young Jr M. D.
Address Univ. Hosp Date signed 11-26-47

Please write plainly. Physicians: please write correct age is especially important.

VS 190

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 557363

557363

108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2700 Hoke N Charles
(c) Hospital or institution: Doctors Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Lemmon St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel S. Longo.

3 (b) If veteran, name war None

3 (c) Social Security Account No. 196-03-127

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Genevieve Morsa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-18-1894

8. AGE: Years 53 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Automotive Mechanic

11. Industry or business

FATHER
12. Name Carmen Longo
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. G. Longo
(b) Address 606 Lemmon St.

17 (a) Burial (b) Date thereof Nov. 24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Throop Pa

18 (a) Funeral director Ted L Beyer Jr
(b) Address 1512 Hollins St

19 (a) NOV 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1947, at 6.47 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1947, to 11/26 1947, and that I last saw h. alive on 11/26 1947.

Immediate cause of death: Pulmonary Embolism and Pneumonia, Bilateral — Duration 13 days.

Due to: Thrombosis of prostatic plexus.

Due to: Prostatic Cancer.

Other Conditions: Prostatic Hypertrophy (congenital) Bladder Calculus (Contributory but not related to cause of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunterton Williams M.D.
Address 2231 Eutaw Pl Date signed 11/26/47

Physicians: please write clearly. Correct age is especially important.

57364 B.C.H. 1-9454 BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 57364
57364 CH. 115396 CERTIFICATE OF DEATH 160A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Brunswick ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allen- Baby Boy (Juanita)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21 - 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Allen
13. Birthplace Ohio

MOTHER
14. Maiden Name Juanita Allen
15. Birthplace Ohio

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 11-25-47
(Burial, cremation, or removal) 9AM (month) (day) (year)
(c) Cemetery or crematory Balo. City Hosp.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) (Signature and title of local registrar) (b) Huntington Williams, M.D. Address Balto City Hosp Date signed 11/26/47

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 - 1947, at 4.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1947, to Nov. 22- 1947 and that I last saw h. im alive on Nov. 22 - 1947

Immediate cause of death	Duration
Fetal Atelectasis	1 day
Due to Diffuse brain hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Arnold H Beaker M.D.

correct age is especially important. Physicians: please write

V S 150 Hospital Disposal X

57365

BALTIMORE CITY HEALTH DEPARTMENT

ISAKOFF CERTIFICATE OF DEATH 83A

Registered No. 57365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Home 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 Quantico Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Isakoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Levy Krasnow
15. Birthplace Russia

16 (a) Informant Ethel Glushakow
(b) Address 2507 Quantico Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eastern Ave

19 NOV 27 1947 (Date rec'd by Registrar) (b) Interred in Fairview Cemetery, Williamsport, Md. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26-1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Nov 26 1947, and that I last saw alive on 11/26 1947

Immediate cause of death: acute cardiac dilatation — Duration

Due to:

Due to: Cerebral hemorrhage

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S C Feldstein M. D.

Address 1440 E Baltimore Date signed 11/26/47

X

correct age is especially important. Physicians: please write clearly

557366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93 D

557366 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 S. Patterson Park ave
(c) Hospital or institution: 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 S. Patterson Park ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

3 (a) FULL NAME Frances Popielek

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Ignatius Popielek
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Francis Blaszczak
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna Jagusyewska
15. Birthplace Poland

16 (a) Informant Mrs Alice Sawinski
(b) Address 1 N. Collington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address 401 S. Chester Street

19 (a) NOV 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VE 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1947, at 3:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19- 1947 to 11-27- 1947 and that I last saw h. alive on 11-22- 1947.

Immediate cause of death: Chron. empyema with bronchopleural fistula
Due to: Terminal bronchopneumonia
Due to: Arteriosclerosis

Duration: 8 days

Other Conditions: Senility.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Summers M. D.
Address 1073 Park ave Date signed 11-28-47

57367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √55E

Registered No. 57367

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address 1714 E. Monument St #5
(c) Hospital or institution: 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Dys
(e) Length of stay in Baltimore (yrs., mos., or days) 34 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Normandy Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY BURNS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Eugene J. Burns
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1912

8. AGE: Years	Months	Days	If less than one day
34	11	21	--hr. --min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Stephen J. McDonough
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Sweiger
15. Birthplace Maryland

16 (a) Informant Eugene J. Burns
(b) Address 510 Normandy Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 NOV 27 1947 (Date rec'd by reg'r) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1947 to 11/26 1947 and that I last saw h.. alive on 11/26 1947

Immediate cause of death	Duration
MELANOCARCINOMA WITH METASTASES (GENERAL)	
Due to WITH ADVANCED	
Due to CACHEXIA	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy SAME AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Susman M. D.
Address Sinai Hospital Date signed 11/26/47

Please write clearly with pen and ink. Physicians: please write correct age is especially important.

657368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5 13

Registered No. 657368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Coldspring Lane
(c) Hospital or institution:
15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Coldspring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Justin Mc-Carthy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
Male	White	Married

6 (b) Name of husband or ~~wife~~ Katherine Mc-Carthy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19 1909

8. AGE: Years	Months	Days	If less than one day
38	0	8	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Patrick Mc-Carthy
13. Birthplace Ireland

MOTHER 14. Maiden Name Catherine Keating
15 Birthplace Ireland

16 (a) Informant Katherine Mc-Carthy
(b) Address 3814 Coldspring Lane

17 (a) Burial, cremation, or removal (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory St Peters Cem
Location Staten Island N Y

18 (a) Funeral director John E Moran
(b) Address 3005 Baltimore St

19 (a) NOV 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased ~~from~~ On 11/27 1947 to 19; and that I last saw h alive on 19

Immediate cause of death	Carcinoma	
Due to	Cancer of Prostate	Duration
Due to		
Other Conditions	Emaciation	

(Include pregnancy within 3 months of death)
Date of operation Hopkins Hospital
Major findings of operation: X ray treatment
of autopsy: and Operation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Karl Trangott
Address 1623 E. N. Ave. Date signed 11/27/47 M. D.

X

Correct age is especially important if deceased was under one year or 100 years or more.

369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52A

Registered No. 657369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3033 E Baltimore
(c) Hospital or institution: 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3033 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNY MAUD EPPELEIN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: CHRISTIAN - H.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MARCH-22-1867

8. AGE: Years: 80 | Months: 8 | Days: 5 | If less than one day: hr. min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business

FATHER
12. Name: ? NICHELSON
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden Name: JULIA NICHELSON
15. Birthplace: WEST VIRGINIA

16 (a) Informant: MRS CORA SPIKER
(b) Address: 3033 E BALTIMORE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 30 1947 (month) (day) (year)
(c) Cemetery or crematory: BETHEL CHURCH
Location: WAVERLY - WEST VIRGINIA

18 (a) Funeral director: H. SNYDER & SONS, INC.
(b) Address: 1649 E. NORTH AVE 13

NOV 28 1947 (Date rec'd by registrar) (b) Livingston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1947 at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1947 to Nov 26 1947 and that I last saw h[illegible] alive on Nov. 26 1947

Immediate cause of death: Carcinoma of Cancer — Duration: 3 Years

Due to: Pulmonary Metastasis — Duration: 6 Weeks

Due to: Hypernephroma - about Left Kidney — Duration: about 2 yrs

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Wm Lewis M. D.
Address 720 E. Monument Date signed 11.27.47

V S 150

Please write plainly. Physicians: please write the cause of death so that the correct age is especially important.

570 X 657570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161A

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution:
Marey Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Penna Ave.
(If rural give location)
(e) Citizen of foreign country? — No (Yes or No)
If yes, name country —

3 (a) FULL NAME Dianna Lynn Digman.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1947

8. AGE: Years | Months | Days 9 | If less than one day 5 hr. 30 min.

9. Birthplace Cumberland, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name George Digman
13. Birthplace West Virginia

MOTHER
14. Maiden Name Nellie Armentrout
15. Birthplace West Virginia

16 (a) Informant George Digman
(b) Address 125 Penna ave. Cumberland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 1947 (month) (day) (year)

(c) Cemetery or crematory Hill Crest Cem.
Location Cumberland, Md

18 (a) Funeral director W. D. Light
(b) Address Cumberland Md

NOV 28 1947 (b) (Date received by registrar) Registrar

Certificate for Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1947, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19, 1947, to Nov. 27 1947, and that I last saw her alive on Nov. 27 1947.

Immediate cause of death Asphyxia — Duration 10 mins

Due to Atelectasis — 10 mins

Due to Aspiration — 10 days.

Other Conditions Bilateral cleft palate & hare lip
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Li Puma M. D.
Address Mercy Hosp Date signed 11-27-47

I certify that the above is a true and correct age is especially important. Physicians: please write clearly

371 Dr Grady 5106 Harford Rd G57371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 G

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4706 Hamper Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Uhrichsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie A Brock

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1874

8. AGE: Years 73 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name (Maiden) Howell
13. Birthplace England

MOTHER
14. Maiden Name (Maiden) Bennett
15. Birthplace England

16 (a) Informant Catherine Tormey
(b) Address 1125 N Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Milton J Dyer
(b) Address 1217 Eutaw St

NOV 28 1947 (Date rec'd by registrar) (b) Curtis Howard Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1947; at 23 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1947 to Nov 26 1947 and that I last saw h[illegible] alive on Nov 26 1947

Immediate cause of death	Duration
Carcinoma of Pancreas	1 Year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July 5 1947
Major findings of operation Cancer of Pancreas
of autopsy no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L L Grady M. D.
Address 5106 Harford Rd Date signed 11/27/47

correct age is especially important. Physicians: please write plainly.

VS 153

3372 JL - 115415 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 1/138 Registered No. 1557372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 25-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3802 Pennington Ave. -25
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1873

8. AGE: Years	Months	Days	If less than one day
74	1	6	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas H. Bowen
13. Birthplace Md.

MOTHER
14. Maiden Name Emmie Porter
15. Birthplace Md.

16 (a) Informant Bs. Co. Hs. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director Wm. Cook Sons
(b) Address 1217 St. Paul St.

19 (a) Date received by registrar (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1947, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1947, to Nov. 24 1947, and that I last saw h. im alive on Nov. 24 1947

Immediate cause of death Pulmonary tuberculosis — Duration 8 mos +

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt. City Hosps Date signed 11/27/47

Please write correct age is especially important. Physicians: please write

V S 150

773

057.373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 N. Hilton St.
(c) Hospital or institution: V°
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 N Hilton St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha K. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Victor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1895

8. AGE: Years	Months	Days	If less than one day
72	0	7	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Samuel T. Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Coleman
15. Birthplace Md.

16 (a) Informant Mrs. Brown
(b) Address 204 S. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director George A. Bailey
(b) Address Baltimore Ave. & Fayette St.

19 (a) NOV 28 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1947, at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Nov. 1947, and that I last saw her alive on Nov. 25 1947

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerotic C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 3325 Eastern Ave Date signed 11/26/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

.74 Both 5-91672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157G

Registered No. 657374

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp. 8/1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2809 Erdman Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Foote

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 20, 1947

8. AGE: Years	Months	Days	If less than one day
		6	11 hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James Foote
13. Birthplace Snow Hill, Md

MOTHER
14. Maiden Name Pauline Baker
15. Birthplace Virginia

16 (a) Informant James Foote
(b) Address 2809 Erdman ave

17 (a) Burial (b) Date thereof 11/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Rd.

NOV 28 1947 (b) Huntington Hilliard, M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1947 to Nov. 27, 1947, and that I last saw h.e.r alive on Nov 27 1947

Immediate cause of death	Duration 10 mins
Respiratory Failure	
Due to Atelectasis, bilateral	?
Due to	
Other Conditions Oesophageal stricture Tracheo-oesophageal fistula (Include pregnancy within 3 months of death)	7 days

Date of operation Nov. 25, 1947
Major findings of operation: Tracheo-esophageal fistula - esophageal stricture
of autopsy: Congenital fistula & stricture

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph Ri Pina M. D.
Address Mercy Hosp Date signed 11-27-47

PLEASE WRITE PLAINLY; use ink. Fill all items; if unknown, write "unknown." Be sure to write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

161 A

7375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

057375
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lake Drive near Linden Ave. Alhambra Apts.

(c) Hospital or institution: 13-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. Alhambra Apts. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BELLE COBLENS FEDERLEICHT.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Jacob Federleicht

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1854.

8. AGE:	Years	Months	Days	If less than one day
	93	2	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Charles Coblens,

13. Birthplace Germany.

MOTHER 14. Maiden Name Sallie Wurtzburger,

15. Birthplace Germany.

16 (a) Informant Mr. Charles C. Federleicht

(b) Address Alhambra Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/47. (month) (day) (year)

(c) Cemetery or crematory Oheb Shalom

Location Balto. Md.

18 (a) Funeral director Harris Levy Funeral Home

(b) Address 1902 Eutaw Place.

1947 NOV 28 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26th. 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947, to Nov 26 1947, and that I last saw h.. alive on Nov 26 1947.

Immediate cause of death	Duration
Myocardial failure	7 mos.
Due to Arteriosclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Frederick Lantz, M. D.

Address Temple Garden Apts. Date signed 11-26-47

PLEASE WRITE PLAINLY. Fill in all blanks with full data. Be sure the causes of death clearly and logically correct age is especially important. Physicians: please write the cau

VS 150

7376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194A

Registered No. 657376

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Give the exact place of death and full name of deceased. If not in a hospital or institution, give residence. Please answer all questions. If the exact information is not known, give the best possible answer. Any false statement may subject the person reporting to penalty. Please see that your certificate is complete and correct and sign it. Do not fail to report at once to the Bureau of Vital Statistics any change in the information given or any additional facts which may be learned relative to this death. Prompt compliance with this request is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4300 La Salle Ave
(c) Hospital or institution: 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 La Salle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Klees

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-3717

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Stella B. Klees

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1872

8. AGE: Years 75 | Months 0 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Frederick Co. Maryland (Town, county, and state)

10. Usual Occupation Carpenter (retired)

11. Industry or business Balto. Transit

MOTHER FATHER

12. Name John Klees

13. Birthplace Maryland.

14. Maiden Name Susan Bowers

15. Birthplace Maryland

16 (a) Informant Mr. John W Klees

(b) Address

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 11-27-47 (month) (day) (year)

(c) Cemetery or crematory Bethel

Location Sams Creek, Carroll Co. Md

18 (a) Funeral director C. M. Wall

(b) Address Winfield Md.

19 (a) NOV 28 1947 (date received by registrar) (b) Registrar for Williamsport Md.

vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1947 to Nov 27 1947, and that I last saw h[illegible] alive on Nov 27 1947.

Immediate cause of death acute Cardiac dilatation

Due to

Due to acute Coronary Infarct

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. C. Fleshman

Address 144 W. Balto St Date signed 11/29/47

7377.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 49

Registered No. 657377

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 S. Chapel Street
(c) Hospital or institution: Home 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 South Chapel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stella Margaret Seifert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~XXXXX~~ Henry
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) April 17-1892

8. AGE: Years	Months	Days	If less than one day
55	7	9	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Tyma
13. Birthplace Poland

MOTHER
14. Maiden Name Louise ?
15. Birthplace Poland

16 (a) Informant Mr. Henry Seifert
(b) Address 408 South Chapel Street

17 (a) Burial (b) Date thereof 11-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~XXXXXXX~~ St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

NOV 28 1947 (b) writing for Williams Hall
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 26, 1947, at 3:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1947, to Nov 26 1947, and that I last saw her alive on Nov 26 1947

Immediate cause of death	Duration
(a) General Carcinomatosis	Since Sept.
Due to (b) Ovarian Carcinoma	1946
Due to (c)	
Other Conditions. General Intestinal	

(Include pregnancy within 3 months of death)
Date of operation July 11-47
Major findings of operation General Carcinomatosis.
of autopsy: ~~XXX~~.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stoney C Ney M. D.
Address 2401 Linden Ave Date signed Nov 26-47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

578 / 46B

Registered No. 557578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2110 Aliceanna Street
(c) Hospital or institution: Home 1-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 31,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 Aliceanna Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-7357

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of wife Lena Thomas
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Jan. 26-1885 ?

8. AGE: Years	Months	Days	If less than one day
62 ?	10	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Wesley Thomas
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Lena Thomas
(b) Address 2110 Aliceanna Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-47 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) NOV 28 1947 (Date rec'd by registrar) Beatrice for Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1947 to Nov. 26 1947 and that I last saw him alive on Nov 26 1947.

Immediate cause of death: CARCINOMA OF STOMACH WITH LIVER METASTASIS — Duration: 9/9/47

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: None

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph F Krauza M.D.
Address 209 N. Chester St Date signed 11/27/47

PLEASE WRITE PLAINLY with pen and ink. Physicians: please write the correct age is especially important.

379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. G57379

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1333 Argyle Ave (If rural, give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Milton William Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colord | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-9-19

8. AGE: Years 28 | Months 5 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Florist Asst.

11. Industry or business

FATHER 12. Name Winfield Jones.
13. Birthplace Md.

MOTHER 14. Maiden Name Pauline Brown
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 28 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McCulloh Street

19 NOV 28 1947 (Date filed by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1947, at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1947 to Nov 24 1947 and that I last saw him alive on Nov. 24 1947.

Immediate cause of death Uremia — Duration .....

Due to Malignant Hypertension — Duration .....

Due to Periarteritis Nodosa — Duration .....

Other Conditions Pneumonia — Duration ona

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Sherman M. Mellinkoff M.D.
Address Johns Hopkins Hosp. Date signed 11/29/47

Physicians: please correct age is especially important.

VS 190

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380

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131B

Registered No. 657380

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Loudon & Green Sts.
(c) Hospital or institution: Univ. Md. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Essex Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Jansen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 27 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Fred W Jansen
13. Birthplace Balto Md

MOTHER 14. Maiden Name Anna Green
15. Birthplace Balto Md

16 (a) Informant Anna Jansen
(b) Address 514 Essex Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-29-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Balto Co

18 (a) Funeral director J. Brundrett
(b) Address 1400 Eastern Ave Rd

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1947, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1947 to 11/26 1947, and that I last saw her alive on 11/26 1947.

Immediate cause of death	Duration
Acidosis	
Due to Uremia	
Due to Chronic nephritis	
Other Conditions Salicylism — Congenital	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Univ Hosp. Date signed 11/26/1947

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

7381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183A

Registered No. 057381

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 561 Prestman St
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 561 Prestman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Levi Sewell Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ollie R. Sewell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1872

8. AGE: Years 72 74 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Calvert Co. Maryland (Town, county, and state)

10. Usual Occupation Insurance Agent

11. Industry or business Mut. Benefit Ins.

FATHER
12. Name Levi Sewell
13. Birthplace Md.

MOTHER
14. Maiden Name Harriett Russell
15. Birthplace Md.

16 (a) Informant Mrs. Ollie R. Sewell
(b) Address 561 Prestman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 NOV 28 1947 Huntington Williams M.D. Registrar
(Date received by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1947, at 2 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/47 to 11/25/47, and that I last saw h alive on 11/24/47.

Immediate cause of death: Lobar Pneumonia

Due to: Hypostatic

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Widcome M. D.
Address 113 N. Eden St Date signed 11/29/47

H. K. Widcome

Carl A. Rizer Mid 11 3 N. Eden St

7382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 C

657382 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution: 11-V

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Fred C. Schanberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ethel R. Francis

6 (c) If alive, give age --years

7. Birth date of deceased (mo., day, yr.) ---------1872

8. AGE: Years 75 | Months --- | Days --- | If less than one day --hr. --min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation General Manager

11. Industry or business Keith's Theatre

FATHER
12. Name Henry M. Schanberger
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Debring
15. Birthplace Maryland

16 (a) Informant Mrs. Ethel R. Schanberger
(b) Address 1114 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Myers and Son
(b) Address 805 N. Calvert Street

19 (a) NOV 28 1947 Registrar (b) Huntington Williams M.D.

FB 180

PLEASE WRITE PLAINLY. Write the causes of death clearly; please write the correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1947, at 12 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Nov. 1947, to 27 Nov 1947, and that I last saw h[illegible] alive on 27 Nov 1947

Immediate cause of death	Duration
Carcinoma of thyroid gland	
Due to Recurrence of tumor in Neck following thyroidectomy	
Due to for Ca.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Thyroidectomy 13 Sep 47
Major findings of operation: Ca of Thyroid
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph R. Sisto M. D.
Address Bon Secours Date signed 27 Nov 47

383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. 657383

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that the age is correctly stated. Be sure that every question is answered. Be especially careful to see that the date of death is correctly stated.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4223 Harcourt Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4223 Harcourt Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kamke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	W

6 (b) Name of husband or wife Ferdinand
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1864

8. AGE: Years	Months	Days	If less than one day
83		28	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Ulrick
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Herget
15. Birthplace Germany

16 (a) Informant Mrs. Walter A. Niemitz
(b) Address 4223 Harcourt Rd.

17 (a) Burial (b) Date thereof 11/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) NOV 28 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1947, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1941 to Nov. 25 1947 and that I last saw h.~~er~~ alive on Nov. 24 1947.

Immediate cause of death	Duration
CEREBRAL THROMBOSIS	3 DAYS
Due to CEREBRAL ARTERIOSCLEROSIS	6 Mos +
Due to	
Other Conditions SENILITY	—

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Machen M. D.
Address 6331 Belair Rd. Date signed 11/26/47

57384

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

657384 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D. of A.
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Ct
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 E Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Harriet Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Chester Pa.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Patheria Jarman
(b) Address 1916 E. Chase St.

17 (a) Burial (b) Date thereof 11/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A. Nelson
(b) Address 1000 Brantly Ave

19 NOV 28 1947 (b) Thomas J. Williams, M.D.
(Date rec'd by registrar)

VS 191

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1947 at 5:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Turbeville M.D.
Medical Examiner.
Date signed 11/25/47

7385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (301)

657385
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5204 Pembroke Ave.
(c) Hospital or institution: None 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5204 Pembroke Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME William C. Wheeler - Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maria Franke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/17/96

8. AGE: Years 51 | Months 2 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Balto - Md
(Town, county, and state)

10. Usual Occupation Automobile Mechanic

11. Industry or business Mack Truck Co.

FATHER
12. Name Wm. C. Wheeler
13. Birthplace Md

MOTHER
14. Maiden Name Kate Stross
15. Birthplace Md

16 (a) Informant Mrs. Marie Wheeler
(b) Address 5204 Pembroke Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-47 (month) (day) (year)
(c) Cemetery or crematory Balto
Location North Ave.

18 (a) Funeral director Libby & Zeiler
(b) Address 403 S. Wolfe St

19 (a) NOV 28 1947 (Date rec'd by registrar) (b) [illegible]

VS 151

Correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Nov., 1947, at 12:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Syphilitic Aortitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ... While at work?
(d) Means of injury

23. Signature Wm. H. Hammer M.D.
Medical Examiner.
Date signed 26 Nov. 1947

X

657386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

657386 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 193
(c) Hospital or institution: Bon Secours Hosp. 4 hrs.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hours.
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 S. Calhoun St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Ellen Winford Summers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Mr. Thomas Summers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/11/1900

8. AGE: Years	Months	Days	If less than one day
47	9	25	hr. min.

9. Birthplace Baltimore (Town, county, and state) Md.
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James W. Walsh
13. Birthplace Balto

MOTHER
14. Maiden Name Margaret J. Walsh
15. Birthplace Balto

16 (a) Informant Honor W. Summers
(b) Address 332 S. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/47 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Washington Blvd

18 (a) Funeral director Lilly & Levin Inc.
(b) Address 413 N. Wolfe St

19 (a) NOV 28 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

PLEASE WRITE PLAINLY, with ink or indelible pencil. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1947, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1947 to Nov. 26 1947 and that I last saw h[illegible] alive on Nov. 26 1947.

Immediate cause of death	Duration
Generalized carcinomatosis	
Due to Breast carcinoma	
Due to	
Other Conditions Cyanosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Odell O. Manner M. D.
Address Bon Secours Hosp. Date signed 11/26/47

VS 250

657387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117 A

657387

Registered No.

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Report the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Be sure that the age is correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Eight St.
(c) Hospital or institution: So. Balto Gen'l Hosp 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore # 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 O'Donnell St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Collier

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Irene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/09

8. AGE: Years	Months	Days	If less than one day
37 38	11	10	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Mechanist
11. Industry or business

FATHER
12. Name James Collier
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah E. Thomas
15. Birthplace Maryland

16 (a) Informant Irene Collier, wife
(b) Address 3313 O'Donell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext.

18 (a) Funeral director Tilley & Zeiler Inc
(b) Address 403 S. Rebecca St.

NOV 28 1947 (Date rec'd by Registrar) (b) Huntingtown Williams, Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26/1947, at 6 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1947, to 11/25 1947 and that I last saw h[illegible] alive on 11/25 1947

Immediate cause of death Respiratory failure — Duration
Due to Pneumonia — Duration
" " Cerebral Embolism — Duration
Due to — Duration
Other Conditions Septic ulcer — Duration

(Include pregnancy within 3 months of death)
Date of operation 11/[illegible]/47 11/26/47
Major findings of operation:
Cerebral
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Herbert Lowell M.D.
Address 1211 Eight St Date signed 11/28/47

7388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 052388

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3719 Northern Parkway
(c) Hospital or institution: 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3719 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE BERNNION

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-28-1874

8. AGE: Years	Months	Days	If less than one day
73	2		hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Thomas Bernnion
13. Birthplace England

MOTHER
14. Maiden Name Ellen Davis
15. Birthplace Ireland

16 (a) Informant Mrs. Deibring
(b) Address 3719 Northern Parkway

17 (a) burial (b) Date thereof 12/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Rd.

19 NOV 28 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28th 1947, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1947, to 11/28 1947, and that I last saw h CV alive on 11/27 1947.

Immediate cause of death	Duration
Bronchu-Pneumonia	3da.
Due to	
Due to	
Other Conditions Atero Sclerotic-Cardio-Vascular disease	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hyman Selkowe M.D.
Address 1106 E Preston Date signed 11/29/47

VS 100

107

7389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 108

652389 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 924 S. Dean St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H MATTHEWS

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-09-1903

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Olivia Page

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1895

8. AGE: Years	Months	Days	If less than one day
51	11		hr. min.

9. Birthplace A. A. County, MD.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business D. E. Foote Canning Co.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Mahaley Henson
15. Birthplace Howard Co., Md

16 (a) Informant Lonnie Thomas (Step Daughter)
(b) Address 924 S. Dean St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Cowan
(b) Address 1216 W. Carlton St.

19 NOV 28 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 191

correct age is especially important. Fully answer every question.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1947, at 1 50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11/25/47

390 BALTIMORE CITY HEALTH DEPARTMENT 657330
CERTIFICATE OF DEATH 131 A Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2310 Guilford Ave
(c) Hospital or institution: 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Guilford ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Pendleton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19 1897

8. AGE: Years 50 | Months | Days 6 | If less than one day hr. min.

9. Birthplace Gloucester Co Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Robt Stath
13. Birthplace Va.

MOTHER 14. Maiden Name Clara Thornton
15. Birthplace Va.

16 (a) Informant Clara Wilkins
(b) Address 2310 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 28 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto County

18 (a) Funeral director Mrs Robt A. Ellwood Dept
(b) Address 1129 N. Caroline St.

19 (a) NOV 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1947, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Nov 25 1947 and that I last saw h[illegible] alive on Nov. 14 1947.

Immediate cause of death: Cerebro-Renal Disease — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration 15 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2329 Guilford Ave Date signed Nov 28 1947

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and in ink. correct age is especially important.

7391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 947

Registered No. 657391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1131 6. Balto St
(c) Hospital or institution: 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sam Sirota

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 48 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Barlay
15. Birthplace Russia

16 (a) Informant Eva Sirota
(b) Address 1131 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-47 (month) (day) (year)
(c) Cemetery or crematory Adas Israel
Location Holport + Gunman Hall Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 406 Eutaw Place

19 (a) NOV 28 1947 (Date—the day, month, year) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27-1947 at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1942 to Nov. 27 1947, and that I last saw h alive on Nov. 27 1947.

Immediate cause of death Cerebral Hemorrhage
Hypertension — Duration 2 years

Due to

Due to

Other Conditions Coronary Heart Disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S M Smith

Address 1223 E. North Ave Date signed 11/28/47 M. D.

V S 150

X

92

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No. 657392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 730 LIGHT ST.
(c) Hospital or institution: 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 LIGHT ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SIDNEY J. HENSLEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	WIDOWED

6 (b) Name of husband or wife - IDA (MORGAN)
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) - FEB 17, 1864

8. AGE: Years	Months	Days	If less than one day
83	9	10	....hr. ....min.

9. Birthplace - WEST VIRGINIA.
(Town, county, and state)
10. Usual Occupation - GROCERY BUSINESS
11. Industry or business -

FATHER
12. Name - UNK.
13. Birthplace - WEST VIRGINIA.

MOTHER
14. Maiden Name - UNK.
15. Birthplace WEST VIRGINIA.

16 (a) Informant - GOBEL HENSLEY
(b) Address 730 LIGHT ST.

17 (a) BURIAL. (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory HUNTINGTON CEM.
Location HUNTINGTON W. VA.

18 (a) Funeral director JOHN F. DENNYLUK
(b) Address 715 LIGHT ST.

19 (a) NOV 28 1947 (Date received by Registrar) (b) [illegible] Huntington, West Virginia

VS 150

PLEASE WRITE PLAINLY with pencil or pen, correct age is especially important. Physicians: please write the causes of death clearly and accurately.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947, at 6:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....,
and that I last saw him alive on Nov. 19 [illegible] 11/27/47

Immediate cause of death Chronic Heart Condition — Duration

Due to Uremia and Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy Not Autopsy.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Natural
(b) Date of occurrence Nov 17 at 4 [illegible] M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work?
(Specify type of place)
(e) Means of injury ✓

23. Signature C. Stamm M. D.
Address 1265 Harrison Ave Date signed

for Dr. J. Subomski by
Howard J. Mencio, M.D.

57393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186 A

Registered No. 657393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Memorial Hospital
(c) Hospital or institution: 33rd & Calvert Sts 19.V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 87 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ~~Samuel~~ Samuel J. Cole

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1860

8. AGE: Years	Months	Days	If less than one day
87	5	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Longshoreman

FATHER
12. Name James D. Cole
13. Birthplace ?

MOTHER
14. Maiden Name Mary Boyce
15. Birthplace ?

16 (a) Informant Hospital record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Balto. Co. Md

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1801 Eutaw Place
NOV 28 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1947, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1947, to Nov 26 1947, and that I last saw h[illegible] alive on Nov 26 1947

Immediate cause of death arteriosclerotic heart disease — Duration one yr. ?

Due to

Due to

Other Conditions Fracture of Rt. Hip — 11 days

(Include pregnancy within 3 months of death)

Date of operation (Compression nail) 11-17-47

Major findings of operation: Fracture of Rt. hip

of autopsy: partially

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 19.V
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 11-15-47 at 7 A M
(c) Where did injury occur? Baltimore, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall to floor

23. Signature George P. Thomas M. D.

Address Union Memorial Hospital Date signed 11-26-47

Howard J. Mearns, M.D.

PLEASE WRITE PLAINLY, with ink. Do not use pencil. Be sure to write the causes of death clearly and legibly. Be sure that the correct age is especially important. Physicians: please write your signature.

VS 150

394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No. 657394

PLEASE WRITE PLAINLY, with pen or pencil. Physicians: please write the causes of death clearly and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 278. Duncan St
(c) Hospital or institution: 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 278. Duncan St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Fisher Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widdow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1901

8. AGE: Years 46 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Handyman

11. Industry or business

FATHER
12. Name Nathaniel Johnson
13. Birthplace Westmoreland Co. Va

MOTHER
14. Maiden Name Eliza Brooks
15. Birthplace Mathews Co. Va

16 (a) Informant Eliza Fisher
(b) Address 203 N. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 29, 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Bentley Apt

19 (a) Nov 28 1947 (b) Huntington Mills Registrar

VS 150

Nov. 26 **MEDICAL CERTIFICATION**

20. **DATE OF DEATH** Nov. 26 1947 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1947 to Nov. 26 1947 and that I last saw him alive on Nov. 21 1947

Immediate cause of death Pulmonary Tuberculosis — Duration 2 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. **Signature** R. W. VM Diamond M. D.

Address 811 N. Caroline St Date signed 11-26-47

X

57395

BALTIMORE CITY HEALTH DEPARTMENT ✓ 657395

CERTIFICATE OF DEATH 127A

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital 26-P
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 232 S. East Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Mary Kuhl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband ~~or wife~~ Thomas G. Kuhl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-26-73

8. AGE: Years 74 | Months 0 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, MD. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business AT HOME

FATHER
12. Name George Sperlein
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Thomas Kuhl
(b) Address 232 S. East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd.

18 (a) Funeral director Charles L. Zerler
(b) Address 901 S. Conkling St.

19 (a) Nov 28 1947 (Date rec'd by Registrar) (b) Huntington Mills, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26- 1947, at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8- 1947, to 11-26 1947. and that I last saw her alive on 11-8-1947

Immediate cause of death	Duration
Cardio Resp. Failure	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation 11-20-47
Major findings of operation: Chronic Cholecystitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martha A Bailey M. D.
Address Date signed

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and supply correct age is especially important.

X

57396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

Registered No. 662396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 d
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 St Paul St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Paul Baker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Not known
Sophia H [illegible] age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1863

8. AGE: Years 84 | Months 2 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name William Baker
13. Birthplace Balto Md

MOTHER
14. Maiden Name Elizabeth Cockey
15. Birthplace Balto Md

16 (a) Informant Miss Eva Baker
(b) Address 1001 St Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 29 1947 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director Henry W Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 NOV 28 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Nov 1947 at 5-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Nov 1947 to 25 Nov 1947 and that I last saw h[illegible] alive on 25 Nov 1947.

	Duration
Immediate cause of death Myocardial insufficiency	1 Wk
Due to Pneumonia, ~~et~~ lobar	1 wk
Due to Hypostatic pulmonary oedema	10 days
Other Conditions Intestinal Obstruction	1 Mo

(Include pregnancy within 3 months of death)
Date of operation 13 Nov 47
Major findings of operation: Adhesions, dilated loops intestine.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard M Garrett M. D.
Address Church Home + Hosp Date signed 26 Nov 47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 057397

57397

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 S. Patterson Pk. Ave.
(c) Hospital or institution: 1-S
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 S. Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antonina Jagoda

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1876

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Stempor
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Mrs. E. Long
(b) Address Bound Brook N.J

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore
18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.
19 (a) NOV 28 1947 (Received by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25/ 47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1947 to Nov. 25 1947, and that I last saw h. alive on Nov. 25 1947

Immediate cause of death	Duration
Pulmonary edema	1
Due to Myocardial Degeneration	second
Due to	
Other Conditions Secondary Anemia	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. F. Ries M. D.
Address 24 S. Bway Date signed Nov. 28/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 657398

657398 467

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Do not write above or below the lines. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St. 17
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 S. Elwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Antoinette Antonia Budacz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 1/6/(70) 1884

8. AGE: Years	Months	Days	If less than one day
63 (64)	10	20	____hr. ____min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Franklin Kutz
13. Birthplace Poland

MOTHER
14. Maiden Name Madelaine Bernacik ouvski.
15. Birthplace Poland

16 (a) Informant Wanda Baranowski
(b) Address 3206 Kenyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19 (a) NOV 28 1947 (Date rec'd by registrar) (b) Funeral for Hollingsworth Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1947, at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1947 to 11/26 1947, and that I last saw her alive on 11/26 1947.

Immediate cause of death	Duration
Cachexia	
Due to Generalized Carcinomatosis	
Due to Carcinoma of Cervix	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/22/47

Major findings of operation: Abdominal Carcinomatosis

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony J. DiPaula M.D.
Address St. Joseph's Hosp. Date signed 11/26/47

657399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 657399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General Hosp. 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 6 dys
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1772 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Heron

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	212-07-0315

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1882

8. AGE: Years	Months	Days	If less than one day
65	5	23	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Alexander Heron
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E. Rice
15. Birthplace Md.

16 (a) Informant Wallace H. Heron Sr.
(b) Address 1772 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) NOV 29 1947 (Month, day, year) (b) Huntington Williams M.D. Registrar

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Nov 1947; at 11:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Sept 1947 to 26 Nov 1947, and that I last saw h[illegible] alive on 26 Nov 1947.

Immediate cause of death	Duration
Cardiac failure.	2 days
Due to Hypertensive cardio vascular disease	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. Allan Aguer M.D.
Address Md. Gen. Hosp. Date signed 26 Nov 47

X

57100 JL - 66101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4.B

Registered No. 57100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Brentwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Gormanly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1867

8. AGE: Years	Months	Days	If less than one day
80	7	13	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Pat Harold
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Nov 29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mayr Calvary Cath.
Location 4300 Old Frederick Rd

18 (a) Funeral director Edgar W. Coughlin Mort.
(b) Address 924 E. Eager St.

NOV 28 19[illegible] (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947, at 11.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1944 to Nov. 27 1947 and that I last saw h[illegible] alive on Nov. 27 1947.

Immediate cause of death	Duration
Resp. failure	6 hrs
Due to Polar pneumonia	3 days
Due to Fracture d neck of fem.	3 yrs
Other Conditions Ca stomach Subacute bact endocarditis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation

of autopsy Ca stomach + S&E

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10-1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5/19/44 at 10 a M
(c) Where did injury occur? 1015 Brentwood Ave Balto (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell to floor
23. Signature [illegible] M. D.
Address Balt City Hosp Date signed 11/28/47

To be approved by Medical Examiner.
For A.R. Dunn by
Edward J. Cushing M.D.

108

V S 150

PLEASE WRITE PLAINLY, with pen and ink. Do not use pencil. Do not write the causes of death clearly and correct age is especially important. Physicians: please write

657401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

657401

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 133 N. Milton ave
(c) Hospital or institution: 62
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 133 N. Milton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Poffel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Michael Poffel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Rutkauzki
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mr. Bernard Poffel (Son)
(b) Address 2502 E. Fairmount ave

17 (a) Burial (b) Date thereof 11-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John F. Weber
(b) Address 401 S. Chester Street

19 (a) NOV 28 1947 Huntingtor Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION 1210

20. DATE OF DEATH Nov 26 1947, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7/47 19 , to 11/25th 1947, and that I last saw h alive on 11/25th 1947.

Immediate cause of death	Duration
Intestinal obstruction	3 days
Due to Carcinomatosis of Intestines	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Sankan M. D.

Address 100 N. Mellowes Date signed 11/26/47

VS 3

57402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49A

Registered No. 57402

PLEASE WRITE PLAINLY, with unfading ink. Use no abbreviations. Be sure to write the causes of death clearly and legibly. Be sure to give correct age. Every item is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmont
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Aberdeen.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 Osborn Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Willie J. Nelson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Divorced

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27, 1906

8. AGE: Years	Months	Days	If less than one day
41 42	0	1	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Secretary.
11. Industry or business

FATHER
12. Name Othor Johnson.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ella Keen.
15. Birthplace Md.

16 (a) Informant Mrs. Katherine Jaconsky
(b) Address 5114 N. Menard Chicago Ill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30-1947 (month) (day) (year)
(c) Cemetery or crematory Spesutia
Location Perryman Md

18 (a) Funeral director Henry Tanney Sons
(b) Address Aberdeen, Md

19 (a) NOV 29 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1947 to 11/28 1947 and that I last saw her alive on 11/28 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Carcinoma of Cervix	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Anothine
Address Church Home Hosp Date signed M. D. 11/30/47

VS 150

65703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 65703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane (W)
(c) Hospital or institution:
Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Montgomery
(c) City or town SPENCERVILLE
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES DUVALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Laura Duvall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1862

8. AGE: Years 84 | Months 11 | Days 13 | If less than one day ....hr. ....min.

9. Birthplace Burtonsville, Montgomery, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Lewis Duvall
13. Birthplace unknown

MOTHER
14. Maiden Name Jane —
15. Birthplace

16 (a) Informant Mrs F.D. Hohmann
(b) Address Burtonsville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1947 (month) (day) (year)
(c) Cemetery or crematory Unicon Cemetery
Location Burtonsville, Md.

18 (a) Funeral director De Witt Donaldson
(b) Address Laurel, Md.

19 (a) NOV 28 1947 (Date rec'd by registrar) (b) Filed by Worthington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947 at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1947 to Nov. 27 1947 and that I last saw him alive on Nov. 27 1947

Immediate cause of death Acute Congestive failure — Duration

Due to arteriosclerotic Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis R. Mazer M. D.
Address 4327 Park Heights Ave Date signed Nov 27, 1947

PLEASE WRITE PLAINLY, with ... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

657404 ✓ 657404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 C

Registered No.

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and in full. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Dr., & 31st Std
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Presstman St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Shaw, William Earl

3 (b) If veteran, name war: WW 2
3 (c) Social Security Account No.: unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Catherine Shaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 13, 1906

8. AGE: Years	Months	Days	If less than one day
41	4	13	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: machinist
11. Industry or business: Metalwork

FATHER
12. Name: Elmer Shaw
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Betty Weedon
15. Birthplace: Baltimore, Md.

16 (a) Informant: Records
(b) Address: U. S Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Frederick Rd.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) NOV 28 1947 (Date rec'd by registrar) (b) Registrar, Baltimore, Md.

MEDICAL CERTIFICATION P

20. DATE OF DEATH 11/26/47 19..., at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26/47 19... to 11/26/47 19..., and that I last saw him alive on 11/26/47 19...

Immediate cause of death	Duration
Peritonitis	16 hours
Due to Perforation of transverse colon	16 hours
Due to Obstruction of descending colon - late radiation reaction following Rx for Seminoma left testis	1 year
Other conditions	

Operation: (Yes or No) (within 3 months of death)
Date of operation 11/26/47
Major findings of operation: above
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stuart M. Sessoms M. D.
Stuart M. Sessoms
Address Marine Hospital Date signed 11/27/47

VS 150

57405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. 57405

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 E 31st St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Charles Brown
Augusta U. Brown 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1879

8. AGE: Years	Months	Days	If less than one day
68	2	4	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Shellhouse & Pipitone Co.

FATHER
12. Name Charles H Brown Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Anne Wales Eversfield
15. Birthplace Virginia

16 (a) Informant Mrs. Charles Brown.
(b) Address 317 E 31st St.

17 (a) Burial (b) Date thereof 11/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Loudon Pk. Cem.
Location Baltimore Md.

18 (a) Funeral director W. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) NOV 28 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

PLEASE WRITE PLAINLY, with unfading ink. Underline the causes of death clearly and legibly. Give correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1947, at 1.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1947, to Nov. 26 1947, and that I last saw h alive on 19

Immediate cause of death Pneumonia
bronchi -

Due to Tumor left lung
apex

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-19-47

Major findings of operation: Tumor apex left lung, type undetermined

of autopsy:

Duration	
Only	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James McC. Finney M. D.
Address Union Memorial Hosp. Date signed 11-26-47

X

57106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 57106

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 E. Biddle
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 E. Biddle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EARL D. NEWTON

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-03-2009

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Sallie B. Newton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1887

8. AGE: Years 59 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Erie Co., N.Y. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name George Henry Newton
13. Birthplace Tenn.

MOTHER
14. Maiden Name Hattie King
15. Birthplace Springfield N.Y.

16 (a) Informant Mr. Lloyde G. Newton
(b) Address 422 E. Biddle St., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/47 (month) (day) (year)
(c) Cemetery or crematory Mortaine Cemetary
Location Baltimore, Md. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Penna. Aves., Baltimore, Md.

19 (a) NOV 28 1947 (Date rec'd by registrar) (b) Certificate for Williams Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27/47 19 at 1:30 AM

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis, M.D. Medical Examiner.

Date signed 11/27/47

Please correct age is especially important. Physician: please

VS 151

57107 CR. 86493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 107

PLEASE WRITE PLAINLY WITH UNFADING INK. Report the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that the information given in each item is complete and correct. Any item which cannot be filled out should be marked "unknown" or "none" as the case may be. The cause of death must be certified to the best knowledge and belief of the physician. Where the cause of death is not due to disease, but to violence, the nature of the injury must be stated, whether accidental, suicidal, or homicidal. Where a woman has died during pregnancy, childbirth, or abortion, the fact should be stated. Where the cause of death is not known, but is only a supposition, the words "supposed to be" should precede the statement of cause. The certificate must be filled out, signed, and returned to the Registrar of the district in which the death occurred, before the body is removed for burial. Where the cause of death is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 E. Monument ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Dolan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10- 1870

8. AGE: Years 77 | Months 5 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Patrick Dolan
13. Birthplace Ireland

MOTHER
14. Maiden Name Helen Caine
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) burial (b) Date thereof 11/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Rd. Baltimore, Md.

18 (a) Funeral director C. E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (NOV 28 1947) (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 - 1947, at 4.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16- 1944, to Nov. 27 - 1947, and that I last saw h im alive on Nov. 27 - 1947

Immediate cause of death	Duration
Cerebro-vascular accident.	
Due to	
Due to	
Other Conditions Arteriosclerotic Heart Disease. Diabetes. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard T. Benford. M. D.
Address Baltimore City Hosp. Date signed 11-27-47

V S 150

83 A

057408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 958

Registered No. 057408

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Clarkson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Mc Quade
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife: July 28 1926
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-28-1926
8. AGE: Years 21 | Months 3 | Days 27 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Mc Quade
13. Birthplace Ba Co. Md.

MOTHER
14. Maiden Name Beulah White
15. Birthplace Balto. Md.

16 (a) Informant Mrs Beulah Mc Quade
(b) Address 1406 Clarkson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Flynn & Flemying
(b) Address 1426 Light St.

19 (a) NOV 28 1947 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1947, at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1947 to 11-26 1947, and that I last saw him alive on 11-26 1947.

Immediate cause of death: Pneumonia Lobar

Due to: Rheumatic Heart

Due to: Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robt. H. Pleasants, M.D.
Address Union Memorial Date signed 11-29-47

X

VS 150

57109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61 ✓

Registered No. 57109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3411 Toone St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 to
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Toone St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Lee Dattin

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Alice
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 20 1871
8. AGE: Years 76 | Months 4 | Days 6 | If less than one day: hr. min.
9. Birthplace: Balto. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: Joseph C. Dattin
13. Birthplace: Balto.

MOTHER
14. Maiden Name: Mary Spinks
15. Birthplace: Balto

16 (a) Informant: Lena C. Dattin
(b) Address: 3411 Toone St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/47 (month) (day) (year)
(c) Cemetery or crematory: Frederick Ave.
Location: Mt. Olivet

18 (a) Funeral director: M. W. E. Dyer's Sons
(b) Address: 620 N. Eutaw & Hoen Sts.

19 NOV 28 1947 (Date rec'd by registrar) (b) Burington for Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1947 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from dead 19 to 19, and that I last saw h[illegible] alive on 26 Nov 19 47

Immediate cause of death	Duration
CORONARY OCCLUSION	
Due to HYPERTENSION	10 yrs.
Due to	
Other Conditions DIABETES	29 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Benjamin Kyle Stein M. D.
Address 1218 N. Highland Ave Date signed 26 Nov. 47

Howard J. Williams, M.D.
94A

57410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 57410

PLEASE WRITE PLAINLY, with unfading ink. Use no abbreviations. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind. (b) County Clinton
(c) City or town Clinton (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roy Schwab

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-19-32

8. AGE: Years 15 | Months 8 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Roy Schwab
13. Birthplace Illinois

MOTHER 14. Maiden Name Mary Keith
15. Birthplace Indiana

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 28-47 (month) (day) (year)
(c) Cemetery or crematory Terra Haute Ind
Location Indiana

18 (a) Funeral director Dillman Cook
(b) Address 1217 St. Paul St

19 NOV 28 1947 (Date filed by Registrar) (b) Hamilton for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1947, at 9 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1947, to Nov 28 1947, and that I last saw h alive on Nov. 28 1947.

Immediate cause of death	Duration
Cardiac failure	20 min
Due to Congenital Heart Disease	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-27-47

Major findings of operation: Cong. Heart Disease

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. Clay M. D.
Address Johns Hopkins Hosp Date signed 11-28-47

57411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 057411

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in the causes of death clearly and legibly. Give correct age in years, months, days, hours, or minutes. Underlining is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3220 McElderry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3220 McElderry St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN A. HAGAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence M Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-8-1876

8. AGE: Years	Months	Days	If less than one day
71	0	18	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Peter Hagen
13. Birthplace ?

MOTHER
14. Maiden Name Mary McKenna
15. Birthplace ?

16 (a) Informant Florence M. Hagan
(b) Address 3220 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 29 47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 6900 Fedrick Road

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St.

19 NOV 29 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 19 47, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1942 to Nov. 26 1947 and that I last saw h alive on 19

Immediate cause of death: Cerebral Hemorrhage
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Williams M.D.
Address 3400 Eastern Ave. Date signed 11-29-47

57412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 111 C

Registered No. 57412

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Chapel Gate La
(c) Hospital or institution: Pimlico Sanatorium
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 Calvaton Heights (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. O'Neill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Bridget

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1880

8. AGE: Years 67 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Francis O'Neill
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Meade
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Roche
(b) Address 2326 Calvaton Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-41 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore Md

18 (a) Funeral director George A. Farley
(b) Address Fulton & Fayette

19 NOV 29 1941 Registration for Williams, M.D. (Date rec'd by registrar)

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1941, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1941 to Nov. 25 1941, and that I last saw him alive on Nov. 25 1941

Immediate cause of death	Duration
Due Myocardial Failure	
Due Hypertension	
Other Conditions Hypostatic pneumonia,	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1123 St Paul St Date signed

X

LEWIS 7

G57113

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1604

G57113 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) All Born

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pikesville, Md
(e) Citizen of foreign country? (Yes or No) (If rural give location)
If yes, name country No

3 (a) FULL NAME Baby Boy Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Rose Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-27-47

8. AGE: Years	Months	Days	If less than one day
0	0	0	2 hr. 30 min.

9. Birthplace Mercy Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dr. Leslie E. Lewis
13. Birthplace Balto

MOTHER
14. Maiden Name Rose Cavanaugh
15. Birthplace Md

16 (a) Informant Mother
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Fearhey
(b) Address Fayette & Eutaw Sts.

19 (a) NOV 29 1947 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1947, at 4:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1947 to 11-27 1947, and that I last saw h[illegible] alive on 11-27 1947.

Immediate cause of death Atelectasis — Duration

Due to Cerebral Hemorrhage

Due to Premature birth

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 11-28-47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G57414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G57414

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in the causes of death clearly and legibly. Give correct age in years, months, days, hours, or minutes, as the case may be. Do not use abbreviations or terms of relationship. Physicians: please write the cause of death in such a way that it can be easily understood. Do not use abbreviations or terms of relationship. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 E. 32nd St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 E. 32nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles William Glaser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed or~~ divorced: Married

6 (b) Name of ~~husband or~~ wife: Louise M. Glaser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 11th 1865

8. AGE: Years 82 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: President

11. Industry or business: Knabe Music Co.

MOTHER | FATHER

12. Name: John Glaser

13. Birthplace: Germany

14. Maiden Name: Katherine Seiman

15. Birthplace: Germany

16 (a) Informant: Alfred W. Glaser

(b) Address: W. Providence Rd. Langdown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park

Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.

(b) Address: 1217 St. Paul St.

19 (a) NOV 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28th 1947, at 5:14 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1947 to Nov 28 1947, and that I last saw him alive on Nov 27 1947

Immediate cause of death: Cardio-Thrombosis — Duration: 2 wks

Due to: Senile Myocarditis — 6 mos

Due to: Arterio Sclerosis — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Huntington Williams M.D.

Address 8 E 39th St Date signed Nov 29/47

VS 150

057115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 057115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts.
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert L. Roop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W. [illegible]

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1867

8. AGE: Years 80 | Months 7 | Days 24 | If less than one day: 2 hr. 17 min.

9. Birthplace Baltimore, Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacob Roop
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Aged Peoples Home
(b) Address 1400 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/47 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ ST. PAUL'S LUTHERAN
Location UPPER CO. MARYLAND

18 (a) Funeral director WILLIAM COOK INC.
(b) Address 1217 ST. PAUL ST.

19 (a) NOV 29 1947 Interring for Williams, Mgr.
(Date of interment) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1947, at 2 17 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1947, to Nov 28 1947, and that I last saw him alive on Nov 28 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Congenital Infant	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph B. Schrock Jr. M. D.
Address Franklin Sq. Hosp. Date signed Nov 29 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

657116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. 657116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4908 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Tucker

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary V. Tucker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1899

8. AGE: Years	Months	Days	If less than one day
48	9	14	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Police Sargeant
11. Industry or business City of Balto

FATHER
12. Name Charles W. Tucker
13. Birthplace Virginia

MOTHER
14. Maiden Name Lottie Munnelly
15. Birthplace Virginia

16 (a) Informant Records
(b) Address Mercy Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul st

19 (a) NOV 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1947, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1947 to Nov 28 1947, and that I last saw him alive on Nov 28 1947

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Coronary Occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Faranio M. D.
Address Mercy Hosp Date signed 11/29/47

VS 150

X

057117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 108

Registered No. 057117

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 N. Carey St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME JAMES HARRIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Richard Harris
13. Birthplace Md.

MOTHER
14. Maiden Name Alyce Diggs
15. Birthplace Md.

16 (a) Informant Elizabeth Crofton
(b) Address 812 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/47 (month) (day) (year)
(c) Cemetery or crematory Coombes, Location Coombes Md

18 (a) Funeral director Rec. H. Kelson
(b) Address 1303 Presstman St

19 (a) NOV 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1947 at 7.45 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Carl L. Royer M.D. Medical Examiner
Date signed 26 Nov 47

PLEASE WRITE PLAINLY. Physicians: please write the correct age is especially important.

VS 161

57118 JL - 80315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 57118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not abbreviate. Give the causes of death clearly and legibly. Be sure to answer every question. Be sure to correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Butler

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1884

8. AGE: Years	Months	Days	If less than one day
63	2	10	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Willie Butler
13. Birthplace Md.

MOTHER
14. Maiden Name Lucreta Baker
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 11 29 1947
(month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balto Md

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill ave

19 (a) Nov 29 1947 (b) Registrar Livingston Williams
(Date filed by Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 19 47, at 7.20P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1945 to Nov. 25 19 47, and that I last saw h im alive on Nov. 25 19 47

Immediate cause of death	Duration
Bronchopneumonia	2 days
Due to Hypertensive Heart Disease & Failure	yrs
Due to	
Other Conditions Hemiplegia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Holcomb Jr. M. D.
Address Balt City Hosp Date signed 11/29/47

57419 LW 87057

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 93D

Registered No. 057119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Give exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 434 Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12- 1871

8. AGE: Years	Months	Days	If less than one day
76	8	14	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Plummer
13. Birthplace Md.

MOTHER
14. Maiden Name Lizzie ?
15. Birthplace Md.

16 (a) Informant B.C.H.Records
(b) Address 4940 Eastern Ave.

17 (a) V (Burial, cremation, or removal) (b) Date thereof 11-29-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Baltimore Co.

18 (a) Funeral director J. Preston Lunberry
(b) Address 519 Mosher St

19 NOV 29 1947 (Date rec'd by registrar) (b) Huntington Willis Registrar M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 19 47, at 6:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20 19 44 to Nov. 26 1947, and that I last saw her alive on Nov. 26 19 47

Immediate cause of death Pulmonary Edema — Duration: days

Due to Cardiac Insufficiency — months

Due to Hypertensive Arteriosclerotic Cardiovascular Disease — years

Other Conditions Coronary Sclerosis — years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed Nov 27-47

CALLY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 1247120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 N. Luzerne Ave.
(c) Hospital or institution: Home (for an year) 1 yr. 10 mo 28 days.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 N. Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA KATHERINE CALLY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	WIDOW.

6 (b) Name of husband or wife DRAGUTIN CALLY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 15 1873

8. AGE: Years	Months	Days	If less than one day
69	11	17	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation YUGO SLAVIA.
11. Industry or business HOUSE WIFE

FATHER
12. Name STEPHAN CETIN
13. Birthplace YUGOSLAVIA.

MOTHER
14. Maiden Name Unknown.
15. Birthplace "

16 (a) Informant ANNA KUHNE
(b) Address 807 N. Luzerne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Dauphin County Pa.

18 (a) Funeral director CHARLES E. SCHUMUNK.
(b) Address 2601-3-5 E. Madison Street.

19 NOV 29 1947 (Date rec'd by registrar) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Nov. 25 1947, at 1:52 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to Nov. 25 1947. and that I last saw her alive on Nov. 25 1947.

Immediate cause of death	Duration
Cardiac FIBROSIS.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen C. Burtham, M. D.
Address 5134 E. Baltimore Date signed 11-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered; if none, write none. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

47

657421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 92B

Registered No. 657421

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lay mill + Dudeland
(c) Hospital or institution:
West Baltimore Gen. Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5713 Chickamin Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jean Kernan.

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N.	M.

6 (b) Name of husband of wife Austin J Kernan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/5/1907

8. AGE: Years	Months	Days	If less than one day
40	10	22	hr. min.

9. Birthplace Baltimore
(Town, county and state)
10. Usual Occupation Home Maker
11. Industry or business

FATHER
12. Name Eugene A Hayden
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elsie Griffin
15. Birthplace Baltimore

16 (a) Informant Mrs A J Kernan
(b) Address 5713 Chickamin Road

17 (a) Burial (b) Date thereof 12/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dans Ridge
Location Catonsville

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 1318 Light St

19 (a) NOV 29 1947 (b) Certified by Justice for Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 November 1947, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Nov 1947 to 27 Nov 1947, and that I last saw h[illegible] alive on 27 Nov 1947.

Immediate cause of death	Duration
Cardiac Failure.	
Due to Rheum. H. Heart Dis	
Cardiac Enlargement	
Due to Aortic Insufficiency	
Mitral Insufficiency & Stenosis	
Pneumonitis	
Other Conditions Congestive Failure	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lester A. Hall Jr. M. D.
Address West Balt. Gen. Hosp. Date signed 11/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 057122

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry William Hooker

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	217-05-2151

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	9	hr. min.

9. Birthplace Union Bridge, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ephriam H. Hooker
13. Birthplace

MOTHER
14. Maiden Name Martha C. Gerber
15. Birthplace

16 (a) Informant Mrs. Florence Hooker
(b) Address 1127 E North Ave.

17 (a) Burial (b) Date thereof 11/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union Bridge
Location Union Bridge Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pk. Aves.

19 (a) NOV 29 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26/47 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1947 to 11/26 1947. and that I last saw h[er] alive on 11/26 1947.

Immediate cause of death	Duration
a Cardiac Insufficiency	
Due to Gen. Arteriosclerosis	
Due to Emphysema	
Other Conditions Bronchitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel L. Grimm MD
Address 1261 E North Ave Date signed 11/28/47 M. D.

37123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. 37123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Baltimore City Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** MARTHA ROBINSON (Roberson)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or ~~wife~~ Samuel Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 10, 1900

8. AGE: Years 47 | Months — | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Hunterman Co. Fla.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Taylor
13. Birthplace Ga.

MOTHER
14. Maiden Name Carrie Taylor
15. Birthplace Ga.

16 (a) Informant Samuel Robinson
(b) Address 1522 E. Lombard St.

17 (a) Burial (b) Date thereof Dec. 1, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Jacksonville, Fla.

18 (a) Funeral director Chas. R. Law
(b) Address 802 Madison Ave.

19 (a) NOV 29 1947 (b) Certificate for Williams M.
(Date rec'd by registrar)

PLEASE WRITE PLAINLY. Physicians: please write the correct age is especially important.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1947, at 5.30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Squamous cancer upper esophagus

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Earl Ryan M.D.
Medical Examiner.
Date signed 11-28-47

57424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83 A

Registered No. 57424

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1348 N. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 1348 N. Fremont (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virgie Epps (Virgie)
3 (b) If veteran, name war
3 (c) Social Security Account No. 143-18-3519
4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Herman Epps
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 28 1896
8. AGE: Years 51 Months 8 Days 29 If less than one day hr. min.
9. Birthplace Loomsbury Co Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Click Jennies
13. Birthplace Unknown
MOTHER 14. Maiden Name Unknown
15. Birthplace
16 (a) Informant Herman Epps
(b) Address 1348 N. Fremont Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 '47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk. Location Arbutus, Md.
18 (a) Funeral director Chas. R. Law
(b) Address 802 Madison Ave.
NOV 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

Please write plainly with pen or pencil, and correct age is especially important. Physicians: please write the causes of death clearly and accurately.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27/47 19..., at 10:05 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Lairs M.D. Medical Examiner
Date signed 11/27/47

X

67125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 67125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State New Jersey (b) County.....
(c) City or town Tea Neck (If outside city or town limits, write RURAL and give town)
(d) Street No. 683 Kent Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ELMER H. COOK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife FERENA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1891

8. AGE: Years	Months	Days	If less than one day
56	2	5	.....hr. .....min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name H.L. Cook
13. Birthplace Westminster, Md.

MOTHER
14. Maiden Name Lucy Wright
15. Birthplace Virginia

16 (a) Informant Mrs. D.B. Seward-Sister
(b) Address 316 Hurley Ave. Hilton Village, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-47 (month) (day) (year)
(c) Cemetery or crematory Bowling Green
Location Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address 1st & Penna Ave

19 (a) NOV 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

PLEASE WRITE PLAINLY, with ink or indelible pencil, and without abbreviations. Give the cause of death clearly and correctly. Items 20 to 23 must be correctly filled in. Physicians: please write the cause of death clearly and correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1947, at 4.05 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular - Renals disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Earle Ryder M.D. Medical Examiner.
Date signed 11-29-47

657:26

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 G

Registered No. 657:26

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. Union St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Chase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Ethel Chase

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1894

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Westminster Carroll Co. (Town, county, and state)

10. Usual Occupation labor

11. Industry or business

FATHER 12. Name Charles Chase

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Jones

15. Birthplace Carroll Co. Md.

16 (a) Informant William Brown

(b) Address Westminster Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1 47 (month) (day) (year)

(c) Cemetery or crematory Ellamont Cem.

Location Westminster Md.

18 (a) Funeral director J. J. Myers, Jr.

(b) Address Westminster Md.

NOV 29 1947 (Date received by Registrar) (Signature) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1947, at 10:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1947 to Nov. 28 1947 and that I last saw him alive on Nov. 28 1947

Immediate cause of death	Duration
respiratory failure	
Due to cerebral metastases	
Due to Carcinoma head of pancreas	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. C. Duvall M.D.

Address University Hosp. Date signed Nov 29

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every answer must be written. Please write the causes of death clearly and legibly. correct age is especially important. Physicians: please w

VS 150

057127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54A

Registered No. 057127

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Middletown
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Orville Ahalt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 12-8-1913

8. AGE: Years	Months	Days	If less than one day
33 34	11	20	hr. min.

9. Birthplace Middletown Fred. Co.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Alonzo Ahalt
13. Birthplace Middletown, Md

MOTHER
14. Maiden Name Nellie Zook
15. Birthplace Middletown, Md

16 (a) Informant Elizabeth Ahalt
(b) Address Middletown, Md.

17 (a) Burial (b) Date thereof 12-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lutheran Cemetery
Location Middletown, Md.

18 (a) Funeral director Blakhill Co.
(b) Address Middletown, Md.

NOV 29 1947 (b)
(Date Rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28 1947, at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1947 to 11/28 1947, and that I last saw h. i.m alive on 11/28 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Mediastinal Depression	
Due to Cerebral Edema	
Other Conditions Post Operative Edema of Left Frontal Lobe	

(Include pregnancy within 3 months of death)
Date of operation 11/27/47
Major findings of operation: Edema right frontal lobe
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Brumbach M. D.
Address Date signed

057128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

057128 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. A correct age is especially important.

1. PLACE OF DEATH: Lunacy Sanitarium Hospital
(a) Baltimore City, Maryland
(b) Street address 5007 Fredk. Ave Frederick Rd Baltimore (29) Md
(c) Hospital or institution: Lunacy Sanitarium Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Mo
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Mo.

2. USUAL RESIDENCE OF DECEASED: Morris, Ill.
(a) State Ill. (b) County
(c) City or town MORRIS
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Miss Catharine C McLean

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-27-1867

8. AGE: Years	Months	Days	If less than one day
80	7	—	hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation School Teacher Retired
11. Industry or business

FATHER
12. Name John McLean
13. Birthplace Scotland

MOTHER
14. Maiden Name Jane Liggett
15. Birthplace —

16 (a) Informant Mrs D McLean (Sister)
(b) Address Avon (Box 136) Ill.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1 (month) (day) 47 (year)
(c) Cemetery or crematory
Location Morris Ill.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1200 Eutaw Place

19 (a) NOV 29 1947 (Registered by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1947, at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1946 to Nov 24 1947, and that I last saw h. alive on Nov 24 1947.

Immediate cause of death	Duration
Pulmonary Oedema	
Due to Arteriosclerosis due to Age & Concomitant Primary Type	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wynne D. Lemmon M. D.
Address Lunacy Sanitarium Date signed

657129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 657129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. If unknown, state "unknown." Do not use dashes or ditto marks. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gilman Apts
(c) Hospital or institution: Calvert & 31st St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. V-V (If outside city or town limits, write RURAL and give town)
(d) Street No. Gilman apts 4 D. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Robert Duff Sloan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Doris Moran Sloan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1906

8. AGE: Years	Months	Days	If less than one day
46	4	6	hr. min.

9. Birthplace S. C. (Town, county and state)
10. Usual Occupation Bank Vice Pres.
11. Industry or business

FATHER 12. Name Robert W. Sloan
FATHER 13. Birthplace S. C.
MOTHER 14. Maiden Name Lillian Trowbridge
MOTHER 15. Birthplace S. C.

16 (a) Informant Doris M. Sloan
(b) Address Gilman Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30/47 (month) (day) (year)
(c) Cemetery or crematory
Location Greenville, S. C.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 900 Eutaw Place

NOV 29 1947 (Date rec'd by registrar) (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Nov. 1947, at 7:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1934, to 28 Nov. 1947, and that I last saw h[illegible] alive on 22 Nov. 1947

Immediate cause of death	Duration Few mins.
Coronary Thrombosis	
Due to Coronary Sclerosis	18 mos.
Due to Hypertension	13 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis E. Wise M. D.
Address 920 St. Paul Date signed 28 Nov. '47

VS 150

57430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. 57430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Erase or write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution: Ardleigh Nursing Home 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Schultz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Unknown

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April ?, 1878

8. AGE: Years	Months	Days	If less than one day
69	7	?	hr. min.

9. Birthplace United States (Town, county, and state)
10. Usual Occupation Self-Notary Public &
11. Industry or business Income Tax Consultant

FATHER
12. Name Mr. Schultz
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Joseph Kadens
(b) Address 16 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29, 1947 (month) (day) (year)
(c) Cemetery or crematory First United Evang. Ch. Cem.
Location Baltimore, Md.

18 (a) Funeral director Wilkes Lamotte
(b) Address 1003 W. Baltimore St.

19 (a) NOV 29 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1947, to Nov 27 1947 and that I last saw him alive on Nov 27 1947.

Immediate cause of death.	Duration
Cerebral Hemorrhage	4 days
Due to Hypertensive Cardio vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harry Glassman M. D.
Address 753 W. Fayette St. Date signed Nov 29 47

X

657431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13D

Registered No. 657431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before it is filed. Answer questions for the causes of death clearly and legibly. correct age is especially important. Physicians: please write the cause of death clearly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1851 N. Collington Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1851 N. Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS ALOIS RINGSDORF

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-05-6320

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margarete E.

6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1893

8. AGE: Years 54 | Months 10 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business: Gas & Electric Co.

FATHER
12. Name: William J. Ringsdorf
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Catherine Bartels
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Margarete Ringsdorf
(b) Address: 1851 N. Collington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) Washington Williams, M.D. Registrar

NOV 29 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1947, at 7.34 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1947 to Nov 25 1947 and that I last saw him alive on 11/24/47

Immediate cause of death: Pulmonary T.B.C. — Duration: 8 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H. Alfred F. Ringsdorf M.D.

Address 1165 S. East Ave Date signed 11/28/47

657432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91A

657432 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4364 Park Heights Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4364 Pk. Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HENRY FULLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Elizabeth (Piepenbring)
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1917

8. AGE: Years	Months	Days	If less than one day
30	2	18	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business Bendix - Towson

FATHER
12. Name Charles R. Fuller
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Maria Holland
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth Fuller
(b) Address 4364 Park Heights Avenue

17 (a) Burial (b) Date thereof 12/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) NOV 29 1947 (b) Huntington Williamsport, Md.
(Date rec'd by registrar)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as directed on the certificate. Give the causes of death clearly and legibly. Special attention is especially important. Physicians: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1947 to Nov. 28 1947; that I last saw h alive on Nov 27 1947.

Immediate cause of death	Duration
Subacute Bacterial Endocarditis	about 3 Mo
Due to	
Due to ?	
Other Conditions Anemia Secondary (Include pregnancy within 3 months of death)	about 4 Mo

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hallie S. Tribbitt M. D.
Address 2220 Garrison Blvd Date signed 12/2/47

VS 150

057133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 947

Registered No. 057133

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 48 E. Henrietta St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 48 E. Henrietta St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN B. NOTTINGHAM

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: DIVORCED
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JANUARY 1882

8. AGE: Years	Months	Days	If less than one day
65	10		hr. min.

9. Birthplace VIRGINIA (Town, county, and state)
10. Usual Occupation PAINTER
11. Industry or business

FATHER
12. Name — UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant — MR D. D. BALLEW
(b) Address 826 LIGHT ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12 / 47 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST -30

19 (a) NOV 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1947, at 10 a M

21. I certify that I took charge of the remains described above, held an Inspection & Exam thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11/25/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Statistical information is required for each death. Please answer each question. Your correct answer is especially important.

67134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 67134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 W. 33rd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 W. 33rd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Maria Stinchecum

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife David George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1855

8. AGE: Years	Months	Days	If less than one day
92	6	23	hr. min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Wm. Dwyer
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah J. Coombes
15. Birthplace Md.

16 (a) Informant Miss Virginia Stinchecum
(b) Address 800 W. 33rd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemt.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pine Ayes

19 NOV 29 1947 (Date rec'd by Registrar) (Signature of Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28/ 1947, at 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1943 to Nov. 27 1947 and that I last saw h. alive on Nov 27 1947

Immediate cause of death	Duration
Myocardial Insufficiency	5 days
Due to Arterio Sclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Arthur J. Dwyer M. D.
Address 800 W 33rd St Date signed 11-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Be sure to write the causes of death clearly and legibly. Be sure to correct age is especially important. Physicians: please write

V S 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57185 105326 138 Registered No. 135 (va)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 750 W. Redwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Marie Best

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23rd 1929

8. AGE: Years	Months	Days	If less than one day
18	6	4	hr. min.

9. Birthplace N. C
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Catherine Henderson
15. Birthplace N. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 11/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory W. H. Rutburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 327 N. Schroeder St

19 (a) NOV 29 1947 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27th 1947 19 , at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1947 to Nov 27th 1947 and that I last saw h. er alive on Nov 27th 1947

Immediate cause of death	Duration
Tuberculosis of Lungs bilateral with Complications	2 yrs
Due to	
Due to	
Other Conditions Chronic Passive Congestion of Liver	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sergio W. Parker M. D.
Address Balt City Hosp Date signed 11-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information among the questions must be answered. Every statement must be complete and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170D

Registered No. 057136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Be sure to write the causes of death clearly and legibly. Be sure to correct age is especially important. Physicians: please write plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town..... (If outside city or town limits, write RURAL and give town)
(d) Street No. 5604 Swift Lane (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ARTHUR BOONE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Georgia Boone

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1914

8. AGE: Years 33 | Months 9 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Memphis Tenn. (Town, county, and state)

10. Usual Occupation Janator

11. Industry or business

FATHER 12. Name Arthur Boone Sr.
13. Birthplace Memphis Tenn.

MOTHER 14. Maiden Name Addie Taylor
15. Birthplace Memphis Tenn.

16 (a) Informant Georgia Boone
(b) Address 5604 Swift Lane

17 (a) Disposal Shipped (Burial, cremation, or removal) (b) Date thereof 11-30-47 (month) (day) (year)

(c) Cemetery or crematory Memphis Tenn.
Location .....

18 (a) Funeral director Mr Katie R. Williams
(b) Address 322 N. Schroeder St

19 NOV 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1947, at 3.20 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 26-6

(a) Date of injury 11-27-47 at 3 p. M.
(b) Where did injury occur? Bobolink Drive Between Redbreast & Swallow Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Driver motorocycle struck tree

23. Signature Earl L. Royer M.D. (Medical Examiner.)
Date signed 11-28-47

657437 BALTIMORE CITY HEALTH DEPARTMENT 657437

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ColdSpring Lane
(c) Hospital or institution:
Cols Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mar yland (b) County Baltimore
(c) City or town Glen Arm P.O.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Dulaney Valley Road
(If rural give location)
(e) Citizen of foreign country? ////// (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA M. STRUTH CLARA MARY STRUTH

3 (b) If veteran, name war ////// | 3 (c) Social Security Account No. //////

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Charles Struth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1885

8. AGE: Years	Months	Days	If less than one day
62	9	15	hr. min.

9. Birthplace BaltimOre, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Joseph Fleckman
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Soeder
15. Birthplace Germany

16 (a) Informant Frank P. Gaines
(b) Address Glen Arm, P.O., Balto. Co., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Maryland

19 (a) NOV 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1947, at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5, 1947 to Nov. 28 1947. and that I last saw her alive on Nov. 28 1947

Immediate cause of death	Duration
Coronary occlusion	
Hypertension Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis K. Mason M.D.
Address 4327 Park Heights Ave. Date signed 11/29/47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Do not use abbreviations. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

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657138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

Registered No. 657138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME GEORGIANNA HARDIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Elder Ellis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1899

8. AGE: Years	Months	Days	If less than one day
48	2	11	hr. min.

9. Birthplace Columbia, S. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Simms
13. Birthplace S. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Elder Ellis Hardin
(b) Address Oakland Park Rd.

17 (a) Burial (b) Date thereof Dec. 1 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Wm. Coy. H. Hall
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 29 1947 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26, 1947, at 9.30P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of heart, with hemorrhage into pericardial cavity.

Fractured ribs

Other Conditions Fractured radius and ulna

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 53-00

(a) Date of injury 11-26-47 at 9 p. M.
(b) Where did injury occur? Randallstown, Winans Rd. near Old Ct. Rd. - Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Yes While at work? No
(d) Means of injury Auto. Passenger-ran into tree

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Give the causes of death clearly and legibly. Underline the correct age is especially important. Physicians: please write the

VS 151

657139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

Registered No. 657139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ray Pye

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of ~~husband~~ or wife Laura R. Pye
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)
10. Usual Occupation Welder
11. Industry or business

FATHER
12. Name Charles Pye
13. Birthplace Clearspring, Md.

MOTHER
14. Maiden Name Lottie J. Mundy
15. Birthplace Williamsport, Pa.

16 (a) Informant Laura R. Pye
(b) Address 1812 Madison Ave

17 (a) Burial (b) Date thereof 11 30 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star Cem.
Location Balto Co.

18 (a) Funeral director Mrs. Bee V. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 29 1947 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1947 at 2:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & avulsion of brain; Multiple fractures of chest (crushed)
Due to Fractured arms and leg bones
Other Conditions Lacerations, bruises, abrasions, and burns
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 3-2
(a) Date of injury 11-25-47 at 2:05 P.M.
(b) Where did injury occur? Pratt & President Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Homer J. Mercer M.D.
Medical Examiner.
Date signed 11-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Report the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 181

57140 X 10Y 64230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Alexandria
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Potomac Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (BRAITH) Beuth George MORRIS

3 (b) If veteran, name war

3 (c) Social Security Account No. 578-07-3897

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Gladys

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.): Feb 3, 1901

8. AGE: Years 46 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Water tender

11. Industry or business U.S. Colored W.T.

FATHER
12. Name Jack Henry Morris
13. Birthplace Va

MOTHER
14. Maiden Name Mary Braithwaite
15. Birthplace Va

16 (a) Informant Fenlock G. Morris
(b) Address Arlington Va

17 (a) Cremation (b) Date thereof 11/29/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director William Lee Sr
(b) Address 1314 Light St

19 NOV 29 1947 (b) Hunter for Williams, M.D.
(Registered by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1947 at 8 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia
Empyema
Due to Fatty degeneration of liver

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use pencil only when necessary. Do not abbreviate. Write the causes of death clearly and legibly. Give correct age in years, months, days. If less than one day, state hours or minutes. Physicians: please write, especially important.

VS 151

657141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 657141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4407 Glen Arm Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME EDWARD WARRINGTON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed, ~~divorced~~.
Male	White	

6 (b) Name of husband or wife Georgeana
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28-1854

8. AGE: Years	Months	Days	If less than one day
93	5		.....hr. .....min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER 12. Name Wm Warrington
13. Birthplace —

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Mr Mills
(b) Address 4407 Glen Arm Ave

17 (a) Burial (b) Date thereof 11-30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Balto

18 (a) Funeral director Jos J. Herndon
(b) Address 3001 Eutaw Ave

19 (a) NOV 29 1947 (b) Trustee for Williams, Mills
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1947, at 8.17 a M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature Carl H. Pyle M.D.
Medical Examiner.
Date signed 11-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in the causes of death clearly and legibly. Physicians: please write the cause of death correctly and legibly. Correct age is especially important.

VS 151

657142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94R

657142 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2733 Baker St.
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2733 Baker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Snively Arthur Helm

3 (b) If veteran, name war: W.W. 1

3 (c) Social Security Account No. 215-05-1139

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lula A. Helm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1900

8. AGE: Years 47 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Waynesboro, Pa.
(Town, county, and state)

10. Usual Occupation Sales Manager

11. Industry or business Martin Bros.

FATHER
12. Name John Helm
13. Birthplace Waynesboro, Pa.

MOTHER
14. Maiden Name Emma Moats
15. Birthplace Pa.

16 (a) Informant Mrs. Lula A. Helm
(b) Address 2733 Baker St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director H Howard Strong
(b) Address 3207 W. North Ave.

19 (a) NOV 29 19[illegible] (Date rec'd by registrar) Waiting for Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1947, at 8.00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1947 to Nov 28 1947, and that I last saw him alive on Nov 28 1947.

Immediate cause of death Coronary Thrombosis — Duration 1 hour

Due to Coronary Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 3033 N North Ave Date signed 12/2/47 M.D.

VS 150

657443

CERTIFICATE CORRECTED 1-14-48 657443

CERTIFICATE OF DEATH 13 A

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2695 Dulany Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2695 Dulany Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Melvin Stocksdale

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose Ella Stocksdale

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) October 17, 1883

8. AGE: Years 64 | Months 1 | Days 11 | If less than one day: hr. min.

9. Birthplace Finksburg Carroll County, Md. (Town, county, and state or foreign country)

10. Usual Occupation Metal Polish Mfg.

11. Industry or business Self

FATHER 12. Name Tobias C. Stocksdale

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Clara Homer

MOTHER 15. Birthplace Maryland

16 (a) Informant Rose Ella Stocksdale

16 (b) Address 2695 Dulany Stead

17 (a) Burial (b) Date thereof 12-1-47 (Burial, cremation, or removal) (month) (day) (year)

17 (c) Cemetery or crematory Finksburg Methodist

Location Carroll County, Md.

18 (a) Funeral director George F. Schwab

18 (b) Address 2101 Frederick Ave.

NOV 30 1947 (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1947, at 12:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1947, to Nov 28 1947, and that I last saw him alive on Nov 28 1947.

Immediate cause of death: Pulmonary Edema / Virus Pneumonitis — Duration

Due to: Myocarditis (Acute Non-Rheumatic)

Due to: Chronic Interstitial Nephritis

Other Conditions: Chronic Hypertrophic Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan C. Kelsey M. D.

Address 251 Wilkens Ave Date signed 11/28/47

657144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

657144 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belvoir Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2413 Freemont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles Zuborwtz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Not known
13. Birthplace " "

MOTHER 14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Joseph Zuborwtz
(b) Address 2219 Mallow Hill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Baltimore

18 (a) Funeral director Geo. A. Daly
(b) Address Fulton & Fayette

19 (a) Filed by registrar Wilmington for Williams, M.D.

NOV 30 1947

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27th. 1947. at 1:20P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10th. 1947. to Nov. 27th. 1947. and that I last saw him alive on Nov. 27th. 1947.

Immediate cause of death: Acute Cardiac Dilitation — Duration few hrs.

Due to: Arteriosclerosis — unknown

Due to: --- ----- —

Other Conditions: Chronic Interstitial Nephritis — unknown
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos. W. Morgenroth M.D.
Address 401 E. 25th. St. Date signed 11/29/47

97

657145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

657145 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3731 Towanda Ave
(c) Hospital or institution: 15 17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3731 Towanda Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS FRANK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Late Rosa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 82 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Isidore Frank
13. Birthplace Russia

MOTHER
14. Maiden Name Dora ?
15. Birthplace Russia

16 (a) Informant Cupple Frank
(b) Address 3731 Towanda Ave

17 (a) Burial (b) Date thereof Nov 30, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) NOV 30 1947 (b)
(Date rec'd by registrar)

Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION 3.10

20. DATE OF DEATH Nov. 29 1947, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1947 to Nov 29 1947 and that I last saw h[illegible] alive on Nov 29 1947

Immediate cause of death	Duration
(a) Bronchial Pneumonia	5 ys
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard J. Haslam M. D.
Address 3331 Eastern Ave Date signed 11/29/47

657146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164 C

657146 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 North Smallwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Yospa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Katie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan, 15, 1882

8. AGE: Years 65 Months 10 Days 13 If less than one day ..... hr. ..... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Shoe Maker

FATHER
12. Name Isidore Yospa
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Katie Yospa
(b) Address 2100 N Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 30, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Nov 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28/47 19..., 9:10p M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Gun Shot Wound right temple

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 15-4
(a) Date of injury 11/28/47 at 10:40 A.M.
(b) Where did injury occur? 2100 North Smallwood
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self-Inflicted, .38 revolver

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 11/29/47

057147 | BALTIMORE CITY HEALTH DEPARTMENT | 057147

CERTIFICATE OF DEATH 56 E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 Ruskin Ave
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 Ruskin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Frank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Balto Md (Town, county and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Lonia
15. Birthplace Russia

16 (a) Informant Margaret Frank
(b) Address 2315 Ruskin ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Lum

18 (a) Funeral director Jack Rewo Inc
(b) Address 2600 Eutaw Place

19 (a) (b)
(Date received by registrar) Registrar

NOV 30 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27-1947 at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1947 to Nov 27 1947, and that I last saw him alive on Nov. 23 1947.

Immediate cause of death	Duration
Coronary Occlusion	2 hrs?
Due to	
Due to	
Other Conditions Papilloma of bladder	?

(Include pregnancy within 3 months of death)
Date of operation Cystoscopy 11/25/47
Major findings of operation: Papilloma of bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Daniel R Robinson
Address 2835 Guilford Ave Date signed 11/28/47 (M. D.)

G57148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G57148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3747 Hickory Avenue
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3747 Hickory Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Jane Filker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11-1867

8. AGE: Years	Months	Days	If less than one day
90 79	10	18	hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Daniel B. Filker
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth A. Burk
15. Birthplace Maryland

16 (a) Informant Daniel B. Filker
(b) Address 3543 Chestnut Avenue

17 (a) Burial (b) Date thereof Dec. 2-1947 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Filth
Location Pennsylvania

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) [illegible] Dr. Williams, M.D. (Date rec'd by registrar) Registrar

NOV 30 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1947, at 1:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947 to Nov 29 1947, and that I last saw h[illegible] alive on Nov 28 1947.

Immediate cause of death	Duration
Myocardial infarction	
Due to Arteriosclerosis	2
Due to Cardiac decomp	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.
Address 3427 Chestnut Ave Date signed Nov. 29-47

657149 BALTIMORE CITY HEALTH DEPARTMENT 657149
CERTIFICATE OF DEATH 122A
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 11
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 W. Coldspring Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Florence E. Caslow

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Laban Caslow (deceased) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1882

8. AGE: Years	Months	Days	If less than one day
65	0	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin Douglass
13. Birthplace Maryland.

MOTHER
14. Maiden Name Rangamma Porter (Not Known)
15. Birthplace Maryland

16 (a) Informant Arthur Caslow
(b) Address 314 W. Coldspring Lane, Balti. 11,
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1-1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 3621 Falls Road
19 (a) NOV 29 1947 (Date received by registrar) (b) Signature of Registrar Lester Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1947, at 8:00 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27 1947, to Nov 28 1947, and that I last saw her alive on Nov. 28 1947

Immediate cause of death: Post-operative strangulated ventral (incisional) hernia — Duration: 5 years for hours.
Due to:
Due to:
Other Conditions: Arteriosclerosis, dehydration
(Include pregnancy within 3 months of death)
Date of operation Nov. 26, 1947
Major findings of operation: Gangrenous bowel.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert Johnson M. D.
Address Mercy Hospital Date signed 11/28/47

VS 150

657150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131A

657150

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 N. 37th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 62 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 N. 37th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alverta V. Pfeiffer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George A. Pfeiffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16-1856

8. AGE: Years 91 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Manchester, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John E. Carl
13. Birthplace Maryland

MOTHER
14. Maiden Name Christina Kessler
15. Birthplace Pennsylvania

16 (a) Informant Jade E. Pfeiffer
(b) Address 1111 N. 37th Street

17 (a) Burial (b) Date thereof Dec 1-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

Funeral director Burgee Funeral Home

(b) Address 3631 Ophls Road

19 (a) (b)
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27- 1947, at 6.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 to Nov 27 1947, and that I last saw her alive on Nov 27 1947

Immediate cause of death Pneumonia — Duration 4 days

Due to Cold

Due to

Other Conditions Arteriosclerotic renal disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. N. Mentzoff M. D.

Address 1500 N. Charles St. Date signed 11/29/47

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65715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

65715 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Oakwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Olp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Naomi Olp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1890

8. AGE: Years	Months	Days	If less than one day
57	2	5	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (b) Date thereof Dec 2, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Rose
Location Rest Lign Pa.

18 (a) Funeral director L. Hepworth & Son
(b) Address 3617 Chestnut Ave

19 (a) (Date received by registrar) (b) Evington Williams M.D. Registrar

NOV 30 1947

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1947 at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1947 to 11/30 1947 and that I last saw h. / alive on 11/30 1947

Immediate cause of death Total heart failure — Duration 3 weeks
Due to arteriosclerotic cardio-vascular dis. — 10 mos.
Due to — 3 years
Other Conditions Possible emphysema, chronic
(Including pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M.D.
Address 1169 H Date signed 11/30/47

657152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 D

657152

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1211 Light St

(c) Hospital or institution: South Balto Gen. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Anne Arundel

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 114 Third Ave, Brooklyn Park
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Thomas W. Zank

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	White	Married

6 (b) Name of husband or wife Frances Zank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1894

8. AGE: Years	Months	Days	If less than one day
53	2	18	hr. min.

9. Birthplace Europe
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Justin Zank

13. Birthplace Europe ?

MOTHER

14. Maiden Name

15. Birthplace Europe

16 (a) Informant wife

(b) Address 114 W. Third Ave.

17 (a) Burial (b) Date thereof Dec 1-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross Polish

Location Dergan Mill Road

18 (a) Funeral director Edward A. Grabinger Jr

(b) Address 423 N. Paca St

19 (a) DEC 1 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1947, at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1947 to Nov 27 1947 and that I last saw h[im] alive on Nov 27 1947.

Immediate cause of death	Duration
(a) Anuria	24 hrs
Due to (b) Chronic nephritis	years
Due to (c)	
Due to (d)	

Other Conditions Hypertensive cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harold Dillon M.D.

Address South Balto Gen Hosp Date signed 11/27/47

VS 150

657153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

657153 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Clifton Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Alice Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife James A. Ross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-28-1867

8. AGE: Years	Months	Days	If less than one day
80	7	29	hr. min.

9. Birthplace Harrisburg, Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Christy
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary J. Brown
15. Birthplace Pa

16 (a) Informant Lillie A. Ross
(b) Address 1915 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park
Location Balto. Co.

18 (a) Funeral director Mrs. Rev. F. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) 11/30/47 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1947 to 11/27 1947.
and that I last saw h[illegible] alive on 11/25 1947.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. R. Leetty M. D.
Address 34 [illegible] Date signed 11/29

057154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 - 057154 / 1947

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 S. Bimney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Lisiewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-1891

8. AGE: Years	Months	Days	If less than one day
56	3	21	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walter Rakowicz
13. Birthplace Poland

MOTHER
14. Maiden Name Joanna Nowak
15. Birthplace Poland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2849 Hudson St

19 (a) 1947 (b) 30 (Rec'd by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947, at 2 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1947, to Nov 27 1947, and that I last saw her alive on Nov 27 1947

Immediate cause of death: cerebral vascular accident / myocardial infarction
Due to: chronic myocarditis / arterial insufficiency
Due to:
Other Conditions: nephrosclerosis - ?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
2 days
1 wk
1926

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Segson M. D.
Address Johns Hopkins Hosp. Date signed Nov 27 47

657155 BALTIMORE CITY HEALTH DEPARTMENT 2 657155
CERTIFICATE OF DEATH 947 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 419 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank H. Pietrowiak
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Anna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1896
8. AGE: Years 51 53 | Months | Days | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business
FATHER 12. Name Joseph Pietrowiak
13. Birthplace Poland
MOTHER 14. Maiden Name Frances Tokod
15. Birthplace Poland
16 (a) Informant Mary Wife
(b) Address 330 S Bond St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave
18 (a) Funeral director John J Duda
(b) Address 2849 Hudson St.
19 (a) NOV 30 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH November 25, 1947 at 11 45 A.M.
21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Pulmonary edema due to coronary disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury
23. Signature [signature] M.D. Medical Examiner.
Date signed 11/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G57156 G57156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 448

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2912 Riggs Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Riggs Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Seibel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Henry W.

6 (c) If alive give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug 2. 1895

8. AGE: Years	Months	Days	If less than one day
52	3	25	hr. min.

9. Birthplace Howard Co. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Charles E. McDonald
13. Birthplace Howard Co. Md

MOTHER
14. Maiden Name
15. Birthplace Howard Co. Md

16 (a) Informant Henry W. Seibel
(b) Address 2912 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 30 Nov. 47 (month) (day) (year)
(c) Cemetery or crematory Springfield Cem.
Location Catonsville Md

18 (a) Funeral director P. B. Shipley & Son
(b) Address 1300 Eutaw Pl.

19 (a) NOV 30 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1932 to Nov. 27 1947.
and that I last saw h[illegible] alive on Nov. 27 1947.

Immediate cause of death

	Duration
Carcinoma of uterus	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July 1947
Major findings of operation: Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard A. Todd M. D.
Address 2108 St. Paul St. Date signed

X

657157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 657157

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince Georges
(c) City or town Mt. Rainier (If outside city or town limits, write RURAL and give town)
(d) Street No. 3601 Oakland Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Barton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Mar.

6 (b) Name of husband or wife Richard O Barton
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) 2/5/10

8. AGE: Years	Months	Days	If less than one day
37	9	24	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William John Sullivan
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah E. ?
15. Birthplace Wash. D.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec. 2 1941
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location (City or town) (County) (State)

18 (a) Funeral director Wahmen E. Pumphrey
(b) Address Silver Springs Md.

NOV 30 1941 (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1941, at 6:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3 1941, to 11/29 1941, and that I last saw h[illegible] alive on 11/29 1941

Immediate cause of death	Duration
Cerebral hemorrhage	1 day
Hypertensive encephalopathy	1 wk.
Due to essential hypertension with uremia	
Due to Chronic glomerulo-nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: ch abnormal coronary sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Sicaport M. D.
Address Johns Hopkins Hosp. Date signed 30 Nov 41

057158

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 510

057158
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street W4
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Stoll St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edgar Donnell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Nell Donnell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 16, 1871

8. AGE: Years	Months	Days	If less than one day
76	6	14	hr. min.

9. Birthplace Berkeley Co. W. Va
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Donnell
13. Birthplace W. Va

MOTHER
14. Maiden Name Dont Known
15. Birthplace

16 (a) Informant Mrs. Charles Donnell
(b) Address Baltimore Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3, 47 (month) (day) (year)
(c) Cemetery or crematory Roydale
Location Martinsburg W. Va
18 (a) Funeral director J. C. Higinbotham
(b) Address Ellicott City Md
19 (Signature of local registrar) (Signature for Milliquin, M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1947, at 5:30 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1947, to Nov. 30 1947, and that I last saw h.im. alive on Nov 30 1947.

Immediate cause of death	Duration
Carcinoma of the prostate gland with generalized metastasis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. M. Carouge M. D.
Address 6226 Everall Ave Date signed 11-30

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D57457 BALTIMORE CITY HEALTH DEPARTMENT 46E Registered No. 457459

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 S Patterson Park
(c) Hospital or institution: 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Caty (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 S Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Dunlap

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Edmund Dunlap

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18 1874

8. AGE: Years 73 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Dont Know

13. Birthplace

MOTHER 14. Maiden Name Dont Know

15. Birthplace

16 (a) Informant Mrs. Agnes Kunek

(b) Address 526 S Rennert Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1/47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Baltimore Co Md

18 (a) Funeral director Wilmot Samuel Kenny

(b) Address 2008 Orleans

19 (a) 11/30/47 (Date rec'd by reg'strar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24 1946 to 11/27 1947 and that I last saw h[illegible] alive on Nov 27 1947.

Immediate cause of death: CARCINOMA OF SMALL INTESTINE — Duration: 4/24/46

Due to

Due to

Other Conditions GENERALIZED ARTERIOSCLEROSIS (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. P. Dunn

Address 209 W. Chester St Date signed 11/28/47 M. D.

VS 150

D 57460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. A 52460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hosp. 7-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842 N Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Knoche

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Madeline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/14/1888

8. AGE: Years 59 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Registrar

11. Industry or business Court House

FATHER 12. Name Louis Knoche

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Fisher

15. Birthplace Md

16 (a) Informant Madeline Knoche

(b) Address 842 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2/47 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto Md

18 (a) Funeral director Ulbrich Funeral Home

(b) Address 2008 Orleans St

19 (a) 12/30/47 (Date rec'd by registrar) (b) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28 1947, at 6 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1947, to 11/28 1947, and that I last saw h. i. alive on 11/28 1947

Immediate cause of death Coronary occlusion — Duration —

Due to Arteriosclerotic heart disease

Due to

Other Conditions Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.

Address 1400 N. Caroline St Date signed 11/28/47

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

D 57461 ✓ 93D — Registered No. D 57461

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (County)
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3077 McElderry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert A. Platz

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna R. Platz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14, 1889

8. AGE: Years	Months	Days	If less than one day
58	10	19	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Insurance
11. Industry or business

FATHER 12. Name Andrew Platz
13. Birthplace Germany

MOTHER 14. Maiden Name Amelia Eisenbrandt
15. Birthplace Germany

16 (a) Informant Herbert A Platz Jr
(b) Address 1359 Clifton Blvd

17 (a) Burial (b) Date thereof Dec 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Clifton

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Oliver St

19 (a) 12/1/47 (b) Huntington Millinger III Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Nov 1947, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Nov 1947 to 29 Nov 1947, and that I last saw him alive on 29 Nov 1947

Immediate cause of death	Duration
Coronary occlusion	1 day
Due to Hypertensive Cardiovascular disease	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Allan Lynch M.D.
Address Md General Hosp Date signed 12/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57169 GM. 115497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

140B (Registered No.)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 E. Eager ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Odessa Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 - 1925

8. AGE: Years	Months	Days	If less than one day
22	6		hr. min.

9. Birthplace VA. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernest Johnson
13. Birthplace VA.

MOTHER
14. Maiden Name Norma Jackson
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30th '47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem. Co.
Location Md

18 (a) Funeral director Ebony Wilson
(b) Address 1000 Brantley Ave

DEC 30 1947 (Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 - 1947 at 12.01 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 - 1947 to Nov. 30 1947, and that I last saw her alive on Nov. 30 - 1947.

	Duration
Immediate cause of death Respiratory failure	10 mins.
Due to pulmonary infarcts	?
Due to generalized septicemia due to acute endometritis	4 days
Other Conditions toxic hepatitis	6 days
bile nephrosis	4 days

(Include pregnancy within 3 months of death)

Date of operation 11/29/47
Major findings of operation: spreading gangrene of the uterus
of autopsy: pulmon. infarcts

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Gordon Craft M. D.
Address Balt. City Hosps Date signed 12/2/47

Duly approved by Medical Examiner Howard J. Carman, M.D.

G57163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111C

G57163 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Hollins St
(c) Hospital or institution: 19-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Eichelberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3. 1883

8. AGE: Years 64 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or Business City

FATHER 12. Name George Eichelberger
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Martha Baldwin
15. Birthplace Baltimore Md

16 (a) Informant Lawrence Eichelberger
(b) Address Finksburg Md

17 (a) Burial (b) Date thereof 12/2/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Madonna Ridge
Location Finksburg Md

18 (a) Funeral director Thilford & Dorsey
(b) Address 1219 Lombard St

19 (a) (b) Huntington Williams M.D.
(Date rec'd by registrar)
DEC 2 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Nov 1947, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Edema
Pulmonary Edema
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed 11/30/47

G57164
AB-114500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G57164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 933 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Faith Hamilton

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21- 1878

8. AGE: Years	Months	Days	If less than one day
69	9	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Yingling
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/2/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 1 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Nov. 29 19 47 at 2.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1947, to 11-29 1947, and that I last saw her alive on 11-29 1947.

Immediate cause of death	Duration
Pneumonia, Left Lower Lobe	2 days
Due to Gangrene Both Legs (Bowel operation)	weeks
Due to Tuberculosis Miliary B. Lobes Lobe,	7
Other Conditions Arteriolar Nephrosclerosis	7

(Include pregnancy within 3 months of death)
Date of operation 10-30-47 & 11-26-47
Major findings of operation: Gangrene of Legs
of autopsy: See Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rush C. Nutterville M. D.
Address Balt. City Hospitals Date signed 11-29-47

G57465 — BALTIMORE CITY HEALTH DEPARTMENT — G57465

CERTIFICATE OF DEATH 193D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 Dichester Ave
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Dichester Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** MARGARET McGuire

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2-1858

8. AGE: Years	Months	Days	If less than one day
88 84	11	26	hr. min.

9. Birthplace Drayton W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Thomas McGuire
13. Birthplace W. Va.

MOTHER — 14. Maiden Name Margaret Fitzpatrick
15. Birthplace W. Va.

16 (a) Informant James Bennie
(b) Address 307 Dichester Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Edmondson Ave. Extended

18 (a) Funeral director Wm Cook Jnr
(b) Address 1217 St Paul St.

19 (a) DEC 1 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1945 to Nov 28 1947, and that I last saw h[illegible] alive on Nov 24 1947.

Immediate cause of death: Myocardial insufficiency — Duration: 2 yrs.
Due to
Due to
Other Conditions: Arteriosclerosis
Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peter A. Schenuit
Address 1337 S. Charles St Date signed 11/29/47 M.D.

657166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 147B

Registered No. 657166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 161
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 hours
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 N Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Mary Phelps S 34820

3 (b) If veteran, name war.....
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Married

6 (b) Name of husband or wife John Phelps.
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Dec 15 1911

8. AGE: Years	Months	Days	If less than one day
35	11	10	....hr. ....min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant John Phelps.
(b) Address 1008 N. Carrollton Ave.

17 (a) Burial (b) Date thereof 12/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Port Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. mount st.

19 (a) DEC 1 - 1947 (b) [illegible] Registrar
(Received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1947, at 4.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1947 to Nov 27 1947, and that I last saw h.er alive on Nov 27 1947

Immediate cause of death	Duration
Septicemia	
Due to Intrapartum infection	
Due to 80 hours post-partum	
Other Conditions hypelemphysis (bilateral cystic) - anemia severe	

(Include pregnancy within 3 months of death)

Date of operation delivery at 9 A.M. 11/24/47
Major findings of operation: delivered at home of full term dead female
of autopsy: [illegible] - endometritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature [illegible] Shea M.D.
Address Univ Hospital Date signed 12/7/47

657167 BENNISON

BALTIMORE CITY HEALTH DEPARTMENT 83A

CERTIFICATE OF DEATH

657167 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Baltimore
(b) Street address 803 N. Parrish st
(c) Hospital or institution: 16-W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5-2 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803-N. Parrish St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Shields Bennison

3 (b) If veteran, name war: World's War I.
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Nellie B. Bennison
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1895
8. AGE: Years 52 | Months | Days | If less than one day hr. min.
9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business:

FATHER
12. Name: —
13. Birthplace: Bennison Md.

MOTHER
14. Maiden Name: Mary Wallace
15. Birthplace: Va.

16 (a) Informant: Nellie B. Bennison
(b) Address: 803. N. Parrish St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/47 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location: Fredericks Ave.
18 (a) Funeral director: Metropolitan Funeral Home
(b) Address: 922. N. mount st.
19 (a) DEC 1 - 1947 (Date rec'd by registrar) (b) Tuttle for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29/47 19 1.30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 11/26/47 19 11/27/47 and that I last saw him alive on 11/27/1947
Immediate cause of death: Heart failure
Due to:
Due to: Hypertension
Other conditions: Cirrhosis of liver
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Manner of injury
23. Signature: H. Barksdale M. D.
Address: 803 N. Carey St Date signed 11/29/47

VS 150

057168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 057168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 E. 32nd St.
(c) Hospital or institution: 41
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 E.32nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archibald Stirling Lingenfelder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Estella nee Griffith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1871.

8. AGE: Years 76 | Months | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Lingenfelder
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma V. Parks
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mary E. Lingenfelder
(b) Address 1722 E. 32nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1/47. (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Gay St.

18 (a) Funeral director Harry H. Leibfle
(b) Address 4101 Edmondson Ave.

19 (a) DEC 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1947, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Nov 28 1947, and that I last saw h[illegible] alive on Nov 28 1947.

	Duration
Immediate cause of death Myocardial Insufficiency	90 Days
Due to Abdominal ascites	2 Mos.
Due to Arterio sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ed. L. Zimmerman M. D.
Address 2954 Hayford Rd Date signed 11/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 657169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Walnut Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME: ROBERT L KOONS Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Koons

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1865

8. AGE: Years: 82 | Months: 3 | Days: 4 | If less than one day: .....hr. .....min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: John A Koons
13. Birthplace: Md.

MOTHER
14. Maiden Name: Georgiana Miller
15. Birthplace: Md.

16 (a) Informant: Mrs Robert Koons
(b) Address: 1102 Walnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville - Md.

18 (a) Funeral director: Harry H Wirth
(b) Address: 401 Edmondson Ave.

19 Dec 1 1947 (a) Whether rec'd by registrar (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1947, at 9:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1947 to Nov 28 1947 and that I last saw h.... alive on Nov 28 1947

Immediate cause of death	Duration
Broncho pneumonia	2 wks.
Due to	
Due to	
Other Conditions Arteria - Sclerosis Cardio - Vascular disease with Early Decompensation	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature: Ernest C. Evans M. D.

Address: Maryland Gen'l Hosp. Date signed 12/28/47

107

652170 B.C.H. 3-94640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160 9

Registered No. 652170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5712 Fenway Essex (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Harper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-13-47

8. AGE: Years	Months	Days	If less than one day
		12h	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name B. M. Harper, Jr.
13. Birthplace

MOTHER 14. Maiden Name Dorothy
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo NOV 28 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 1 - 1947 (Date rec'd by registrar) (b) Hunter for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1947, at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1947 to Nov 24 1947, and that I last saw he alive on Nov. 24 1947

Immediate cause of death	Duration
Intracranial Hemorrhage	12 days
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Lyons M. D.
Address Johns Hopkins Hospital Date signed 11-25-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 57171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Monroe St.
(c) Hospital or institution: 164
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: FRANK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1894

8. AGE: Years: 53 | Months: 4 | Days: 26 | If less than one day: hr. min.

9. Birthplace PERRY, GA. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace GA.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant MRS. AMELIA SMITH
(b) Address 1800 W. LAFAYETTE AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Lew. A. Hollan
(b) Address 1631 Druid Hill Ave

DEC 1 - 1947 (a) (Date rec'd by registrar) (b) Huntingtown, Md.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1947, at 4 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to

Other Conditions Fracture left, acetabulum,
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-21-47 at 9.30 a. M.
(b) Where did injury occur? Monument & Rutland, Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Pedestrian struck by auto

23. Signature Carl L. Pryer M.D.
Medical Examiner.
Date signed 11-29-47

X

157172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95-C

Registered No. 157172

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Mt. Holly St.
(c) Hospital or institution: 20-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Emma E. Pistel

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FM	W	Widowed

6 (b) Name of husband or wife John L. Pistel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1870

8. AGE: Years	Months	Days	If less than one day
77	11	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John G. Sauner
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth A Schley
15. Birthplace Maryland

16 (a) Informant Mrs. Elizabeth Peddicord
(b) Address 413 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director George W. Little
(b) Address 2[illegible] Edmondson Ave.

19 (a) DEC 1 - [illegible] (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1947 19 , at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1947 to Nov 29 1947.
and that I last saw h[illegible] alive on Nov. 28 1947.

Immediate cause of death Myocardial failure.
Hypertensive and Arteriosclerotic heart disease
Due to Acute Coronary thrombosis & Congestive failure.
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

I certify
Severed
Yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Michel M.D.
Address 2901 Edmondson Date signed Nov 29 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 057173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3512 Clifton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William Clifford Gambrell

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: Yes No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1883

8. AGE: Years 63 | Months 11 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Electrician Retired

11. Industry or business The Hub

FATHER
12. Name Albert F. Gambrell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lilly North
15. Birthplace Balto. Md.

16 (a) Informant Mrs Nellie L. Gambrell
(b) Address 3512 Clifton Ave.

17 (a) Burial (b) Date thereof 12/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Date received) DEC 1 1947 (Registrar) Huntington Mitchell

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1947, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to 11/27 1947 and that I last saw him alive on 11/27 1947

Immediate cause of death	Duration
Cerebral hemorrhage	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Reiter M. D.
Address 3408 Windsor Ave. Date signed 11/29/47

V S 150

057474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 B

Registered No. 057474

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave.
(c) Hospital or institution: Southern Hospital & Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County Carteret
(c) City or town Beaufort
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Hiram Wesley Styron

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6. (b) Name of husband or wife: Rena E. Fodrie
6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Sept. 22, 1868

8. AGE: Years: 79 | Months: 2 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Hatteras, Dare County, N. C. (Town, county, and state)

10. Usual Occupation: Engineer - retired 15 years

11. Industry or business: U. S. Army Engineer Service

FATHER
12. Name: James E. Styron
13. Birthplace: Hatteras, N. C.

MOTHER
14. Maiden Name: Harriet O'Neil
15. Birthplace: Hatteras, N. C.

16 (a) Informant: Manley James Styron
(b) Address: 3710 Elkader Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery: Ocean View
Location: Beaufort, N. C.

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place

Dec 1, 1947 (b) Fenton for Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20. 1947 to Nov. 30 1947. and that I last saw him alive on Nov. 29. 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage.	9 da.
Due to	
Due to Old Age	
Other Conditions Hypertension.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert C. Blake M.D.
Address Medical Arts Bldg. Date signed 12-1-47

Dr. Herbert C. Blake

0574175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. 0574175

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 South Broadway
(c) Hospital or institution: Home 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 South Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Andrzej Karcz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of [redacted] wife Agnes Karcz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1st 1882

8. AGE: Years	Months	Days	If less than one day
65	1	29	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Tavern Owner
11. Industry or business

FATHER
12. Name Frank Karcz
13. Birthplace Poland

MOTHER
14. Maiden Name Agnes Sobiak
15. Birthplace Poland

16 (a) Informant Mrs. Agnes Karcz
(b) Address 805 South Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-47 (month) (day) (year)
(c) Cemetery [redacted] St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

DEC 3 1947 (Date received by registrar) Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1947, at 9 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to Nov 30 1947, and that I last saw h[redacted] alive on Nov 30 1947

Immediate cause of death: Arteriosclerotic C.V. Disease — Duration: June 15/47
Due to: Myocardial Failure
Due to:
Other Conditions: None.
(Include pregnancy within 3 months of death)
Date of operation: None.
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fairchemnt M. D.
Address 142 S. Eutaw St. Date signed 11-30-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 057176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 32nd Sts.
(c) Hospital or institution: Union Memorial Hospital 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20.
(e) Length of stay in Baltimore (yrs., mos., or days) Ca. 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Gittings Ave. # 12
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Curtis F. Burnam

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Florence Burnam
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 1/17/1878

8. AGE: Years	Months	Days	If less than one day
69	10	12	hr. min.

9. Birthplace Kentucky
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Anthony R. Burnam
13. Birthplace Kentucky

MOTHER
14. Maiden Name Margaret Summers
15. Birthplace Kentucky

16 (a) Informant Daughter Mrs. Howard Smith
(b) Address 103 Glendale Road, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Baltimore Co.

18 (a) Funeral director John D. Mitchell Funeral
(b) Address 1400 Eutaw Place

19 (a) DEC 1 1947 (b)
(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1947, at 9:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1947, to 11/29 1947, and that I last saw him alive on 11/29 1947.

Immediate cause of death	Duration
Pneumonia, R.V.L.	7 da.
Due to	
Due to	
Other Conditions A-S heart disease & cardiac decompensation	6 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman Jr. M.D.
Address Union Memorial Hospital Date signed Nov 29 1947

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

Registered No. 157177

157177

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 N. Rose St.,
(c) Hospital or institution: T.V.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 N. Rose St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gustav J. Blaha

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of ~~husband~~ or wife Josefa (nee Bohac)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1855

8. AGE: Years 92 | Months | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Frank J. Blaha - son
(b) Address 716 N. Rose St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) DEC 1 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1947, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to Nov. 28 1947 and that I last saw him alive on Nov 25 1947.

Immediate cause of death: Acute Cardiac Failure — Duration: 1/2 hr.

Due to: Arteriosclerotic Heart Disease — Duration: 10 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2413 E. Monument St Date signed 11/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. 057178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1604 Morland Ave
(c) Hospital or institution: 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Morland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Klatzky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Jacob
13. Birthplace Russia

MOTHER 14. Maiden Name Tobie
15. Birthplace Russia

16 (a) Informant Lena Klatzky
(b) Address 1604 Morland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-47 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) Registered by (signature) for Williams Mortuary

DEC 1 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30-1947, at 01 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1931, to Nov. 30 1947, and that I last saw h.i.m. alive on Nov. 30 1947

Immediate cause of death: Cerebral hemorrhage — Duration 5 days

Due to: Hypertension — 7 years.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. A. Gilmore M. D.
Address Temple Gardens Apts. Date signed 12/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1557179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1313

Registered No. 1557179

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Carlington Ave
(c) Hospital or institution: 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Carlington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kilduff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1 1863

8. AGE: Years 84 | Months 1 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Kilduff
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Cecilia Hauser
15. Birthplace Unknown

16 (a) Informant Mary A. Kilduff
(b) Address 608 Carlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C Moran
(b) Address 3600 Baltimore St

19 (a) DEC 1 - 1947 (Date rec'd by registrar) (b) Interment or Removal, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1947 at 7 00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 7 1947 to Nov 29 1947 and that I last saw alive on Nov 28 1947.

	Duration
Immediate cause of death (a) Arteriosclerosis	
Heart Disease	Over 1 yr.
Due to (b) Generalized Arterio-sclerosis	Over 1 yr.
Due to	
Other Conditions Chronic nephritis. Prostatic hypertrophy. (Include pregnancy within 3 months of death)	Over 1 yr.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Dennyer M. D.
Address 4808 Harford Rd. Date signed 11/30/47

VS 150

93D

657480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94P

657480 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 134 N Luzerne Ave 62
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 134 N Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.
Male	White	Married

6 (b) Name of husband or ~~wife~~ Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10 - 1883

8. AGE: Years	Months	Days	If less than one day
64	1	19	hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry or business

FATHER
12. Name Frank Mitchell
13. Birthplace Unknown

MOTHER
14. Maiden Name Josephine
15. Birthplace Unknown

16 (a) Informant Marie Mitchell
(b) Address 134 N Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 DEC 1 - 1947 (Date rec'd by registrar) (b) Thomas for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1947 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947 to Nov 28 1947, and that I last saw h alive on Nov 29th 1947.

Immediate cause of death Coronary Thrombosis — Duration 2 hours
Due to Arteriosclerosis — 8
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature X H. J. Tankersley M. D.
Address 100 Wellesley Date signed 11/30/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657181 BALTIMORE CITY HEALTH DEPARTMENT 131B Registered No. 657181

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 BATTERY AVE
(c) Hospital or institution: 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 BATTERY AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE M. WAGNER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-10-2001

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOWER

6 (b) Name of husband or wife LILLIAN MAY WAGNER

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) AUG 29-1884

8. AGE: Years 63 | Months 3 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation PRODUCE DEALER

11. Industry or business —

FATHER 12. Name MICHAEL WAGNER

13. Birthplace BALTIMORE MD

MOTHER 14. Maiden Name ANNA C. SCHUTTER

15. Birthplace BALTIMORE MD

16 (a) Informant MRS ANNA M WHITLEY

(b) Address 1205 BATTERY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-3-47 (month) (day) (year)

(c) Cemetery or crematory BALTIMORE CEM. Location BALTO. MD.

18 (a) Funeral director Bernard C. Hartle

(b) Address 121 E West St

19 (a) DEC 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 30 1947 at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1947 to Nov 05 1947 and that I last saw h[illegible] alive on Nov 30 1947

Immediate cause of death Chronic Endocarditis — Duration 2 mos

Due to Arterio Sclerosis — 3 mos

Due to - Chronic Nephritis — 6 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H M Whitley M. D.

Address 1279 Mulberry St Date signed 12/4/47

657182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

657182 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 676 W. Fairmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** JOSEPH JOHNSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years 29 | Months | Days | If less than one day hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Ralph Johnson
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Mary Parker
15. Birthplace Richmond Va.

16 (a) Informant Mary Brown
(b) Address 676 Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location MD

18 (a) Funeral director F. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 1 - 1947 (Date rec'd by registrar) for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1947, at 4.55 a M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions Tuberculosis-Tenosynovitis, left wrist.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. Medical Examiner.
Date signed 11-29-47

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

183 B-104177

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131A

057183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 N. Carey Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Batson (Henry).

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-?-1881

8. AGE: Years	Months	Days	If less than one day
66	6		hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Cicero Henry
13. Birthplace N.C.

MOTHER
14. Maiden Name Nora Henry ?
15. Birthplace N.C.

16 (a) Informant Record-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec. 1 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director H. Halstead
(b) Address 915 Druid Hill Ave.

19 DEC 1 - 1947 (By) for Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25- 1947, at 3.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31- 1946, to 11-25- 1947, and that I last saw her alive on 11-25- 1947.

Immediate cause of death	Duration
Pulmonary Edema	days
Due to Cardiac Insufficiency	months
Due to Arteriosclerotic Hypertensive Cardiovasc. Disease.	years
Other Conditions Arteriosclerosis.	years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr.
Address Baltimore City Hosp. Date signed 11-27-47 (M. D.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. G57184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 North Milton
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 North Milton (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Duke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Frederick N. Duke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1869

8. AGE: Years	Months	Days	If less than one day
78	2	13	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant George Duke (son)
(b) Address 12 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-1947 (month) (day) (year)
(c) Cemetery or crematory Trinity Cem.
Location O'Donnell St. Baltimore

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe St.

DEC 1 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30/47 19..., at 5 o'clock P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Dawe M.D. Medical Examiner.
Date signed 11/30/47

657185 BALTIMORE CITY HEALTH DEPARTMENT 657185
CERTIFICATE OF DEATH 93D Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 249 South Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA OSTROWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Michael Ostrowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 63 yrs Months Days If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Michalkiewicz
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Michael Ostrowski
(b) Address 249 S. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 3/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozgozuski
(b) Address 1930 Eastern Ave

19 (a) [illegible] (b)
Registered by registrar Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30/47 19 , at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D. Medical Examiner.
Date signed 11/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 657186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1456 Riviera Ave
(c) Hospital or institution: 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1456 Riviera Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Johnson

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Charles Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1872

8. AGE: Years	Months	Days	If less than one day
75	1	16	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Deltus
13. Birthplace Germany

MOTHER
14. Maiden Name Dora [redacted] ?
15. Birthplace Germany

16 (a) Informant Mrs. Martin Ryan
(b) Address 1456 Riviera Ave

17 (a) Burial (b) Date thereof Dec 1 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Patapsco Highway

18 (a) Funeral director Crayon Funeral Home
(b) Address 216 N. Charles St.

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) Washington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1947 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Nov 24 1947 and that I last saw h[illegible] alive on Nov 28 1947

Immediate cause of death: Exhaustion — Duration: 3 days
Due to Carcinoma of Uterus — 4 Years
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Dambach M. D.
Address 1644 Hanover Date signed 11/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57187 ✓ G57187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93E

Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 W. Lanvale St
(c) Hospital or institution: 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) yes 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Reese

3 (b) If veteran, name war	3 (c) Social Security Account No.
	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Widower

6 (b) Name of husband or wife Sarah Reese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15, 1872

8. AGE: Years	Months	Days	If less than one day
70	3	13	hr. min.

9. Birthplace Sumter, S. C. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Washington Reese.
13. Birthplace Sumter, S. C.

MOTHER
14. Maiden Name Phillis Morrow.
15. Birthplace Sumter, S. C.

16 (a) Informant Samuel Reese, Jr.
(b) Address 1520 W. Lanvale St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Sumter, S. C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 W. Lafayette Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 1 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-28-1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26-1947 to 11-28-1947 and that I last saw him alive on 11-28-1947.

Immediate cause of death	Duration
Cerebral hemorrhage	3 days
Due to	
Due to	
Other Conditions Myocardiotis	Workman

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving A. Saunders M. D.
Address 529 N. Stricker St. Date signed 11-29-1947

83 A

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057188

BALTIMORE CITY HEALTH DEPARTMENT

113428 CERTIFICATE OF DEATH 93D

057188

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals 18-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 829 W. Mulberry St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Julia Hall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27th 1855

8. AGE: Years	Months	Days	If less than one day
92	8		hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Solomon Hall

13. Birthplace Maryland

MOTHER

14. Maiden Name Catherine Hall

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof Dec. 1, 1947

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Wm. Peter Williams

(b) Address 322 W. Saratoga St.

19 (a) Edington Williams Registrar

(Date filed by registrar)

DEC 5 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27th 1947 19 , at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29th 1947 to Nov. 27 1947 and that I last saw her alive on Nov 27th 1947.

Immediate cause of death	Duration
Cardiac Failure,	
Due to Arteriosclerotic Heart Disease	yrs. yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. E. Kalemian Jr. M. D.

Address Balt City Hosp Date signed 12/1/47

057189 BALTIMORE CITY HEALTH DEPARTMENT 1108 057189
Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp. 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 789 George St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve Morris

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	~~M~~ W

6 (b) Name of husband or wife Benjamin Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1893.

8. AGE: Years	Months	Days	If less than one day
54	4	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name John B. Jones.
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Sarah E. Morris
15. Birthplace Baltimore, Md.

16 (a) Informant Lilian Emory
(b) Address 789 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-1947 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date received by registrar) (b) Clayton Hill, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1947, at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1947 to Nov 27 1947, and that I last saw h[illegible] alive on Nov 27 1947.

Immediate cause of death	Duration
a Pneumococcal Meningitis	5 Days
Due to Lobar Pneumonia	7 Days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Edmonds M. D.
Address Sydenham Hosp. Date signed 11-28-47

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 30

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Dennis

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Jasper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1875

8. AGE: Years	Months	Days	If less than one day
72 ?			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Jim Hammon
13. Birthplace ?

MOTHER
14. Maiden Name Eliza ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. A. Kelson
(b) Address 130 Baltimore [illegible] Baltimore, Md

DEC 1 1947 (a) (b)
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947, at 4.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1943 to Nov. 27 1947, and that I last saw h 9Falive on Nov. 27 1947.

Immediate cause of death Pulmonary Edema — Duration: week

Due to Cardiac failure — months

Due to Hypertensive Cardio-vascular Disease — years

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 11-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657191 657191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 Bruce St
(c) Hospital or institution: 191
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Miles
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex m | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Christina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/30/1874

8. AGE: Years 73 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

MOTHER / FATHER
12. Name Ed
13. Birthplace —
14. Maiden Name Emma
15. Birthplace Md

16 (a) Informant Mabel Martyn
(b) Address 1711 Mahon Ave

17 (a) Burial (b) Date thereof 12/1/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

1947 Funeral director Hes. H. Kelson
(b) Address 1330 Westmount Ave

19 (a) [illegible] Huntington Williams M.D. Registrar
(Date received by registrar) DEC 2 1947

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1947, at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1947 to Nov. 28 1947, and that I last saw h/[illegible] alive on Nov. 4 1947

Immediate cause of death Congestive Heart Failure — Duration 6 weeks
Due to Arteriosclerotic Heart Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. W. Nettleship M.D.
Address 710 N. Johns Pl. Date signed 12/1/47

657492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

657492 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 542 Mc Mechen St
(c) Hospital or institution: —
14 V
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 542 Mc Mechen St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Etta Sprouse

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Kates
13. Birthplace Easton, Maryland

MOTHER
14. Maiden Name Stella Austin
15. Birthplace Easton, Maryland

16 (a) Informant Mrs. Mary Spencer
(b) Address 542 Mc Mechen

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Joseph L. Lucas per e.j.
(b) Address 1400 Mc Culloh St.

19 (a) DEC 1 - 1947 (Date rec'd by registrar) Hunting ton Williams, M.D. (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947, at 11:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1947 to 11-27 1947 and that I last saw h. ex alive on 11-27 1947

Immediate cause of death	Duration
Myocardial Degeneration	—
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Franklin Phillips M. D.
Address 1243 Penna Ave Date signed 12/1/47

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44B

Registered No. 657493

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1848 W. Wolfe (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Gustav Ay. (GUSTAV ADOLPH AY)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. none

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Ada Ay

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) April 4, 1890

8. AGE: Years 57 | Months 7 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Barber, Carpenter

11. Industry or business

FATHER — 12. Name Mr. Gustav Ay.
13. Birthplace Germany

MOTHER — 14. Maiden Name Miss Augusta SCHMIDT
15. Birthplace Germany.

16 (a) Informant Mrs. Gustav Ay
(b) Address 1848 W. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 DEC 1 - 1947 Date rec'd by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30/47 19 , at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13/47 19 to 11/30/47, and that I last saw h[illegible] alive on 11/31/47

Immediate cause of death: Hodgkin's disease with Retroperitoneal glands & liver infiltration — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: Retroperitoneal nodes

of autopsy: Complete hepatic nodes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph D Antonio M.D.
Address Church Home & Hosp. Date signed 11/30/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

357194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55 E

357194 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3603 Fait Ave.
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CATHERINE M. FLECKENSTEIN

3 (b) If veteran, name war: ------
3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: -----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1890.

8. AGE: Years	Months	Days	If less than one day
57	4	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation House-Work
11. Industry or business At Home.

FATHER
12. Name Jacob Fleckenstein
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kreller
15. Birthplace Baltimore, Md.

16 (a) Informant Elizabeth Zinkand (Sister)
(b) Address 3603 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-47. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd.

18 (a) Funeral director Charles L. Zeiler.
(b) Address 901 S. Conkling St.

DEC 1 - 1947 (Date rec'd by Registrar) (Signature) Hunter for Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30/47. 19 at 7:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1947 to Nov 30 1947 and that I last saw h.. alive on Nov 29 1947

Immediate cause of death: Carcinoma of Mesentery - Sarcoma of Diaphragm

Duration
3 mo
4 yr

Due to pleurisy left thumb - Metastasis - to ascites

Due to 2 days -

Other Conditions Pulmonary Embolism Bilateral -
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: exploratory

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. J. Williams M. D.
Address 3 W. Read St. Date signed 12/2/47

057195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 73D

Registered No. 057195

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Edgemere
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 S. Snyder Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Jubb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Andrew Jubb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23 1883

8. AGE: Years	Months	Days	If less than one day
64	6	7	hr. min.

9. Birthplace Warsaw Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Myron Henson
13. Birthplace Virginia

MOTHER
14. Maiden Name Jane Jenkins
15. Birthplace Virginia

16 (a) Informant Nursing Records
(b) Address

17 (a) Burial (b) Date thereof Dec. 3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John L. Miller
(b) Address 2334 Jefferson St.

19 (a) DEC 1 - 1947 (b)
(Date rec'd by registrar)
Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1947, at 3:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1947, to Nov 30 1947, and that I last saw her alive on Nov 29 1947.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Arteriosclerosis Anemia	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Evidence of Anemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. Ley Morrow M. D.
Address Church Home & Hosp. Date signed 30 Nov 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. No. Day
4 E. 33rd Street

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. 27196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1345 Gorsuch Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1345 Gorsuch Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Ackerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John Ackerman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1873

8. AGE: Years	Months	Days	If less than one day
74	0	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Bernard Oberman
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Bust Oberman
15. Birthplace Germany

16 (a) Informant Mr. Bernard J. Ackerman
(b) Address 2812 Pinewood Avenue, 14

17 (a) Burial (b) Date thereof 12-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) DEC 1 - 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1947, to Nov 29 1947, and that I last saw h. alive on Nov. 29 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Thrombosis	
Due to Hypertension, Arteriosclerotic Cardiovascular disease	
Other Conditions Complete Carcinoma Colon.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howland Edward Day M. D.
Address 4 - E-33rd St Balto Md Date signed Dec. 1/947

057497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186A

Registered No. 057497

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph Hosp.
(c) Hospital or institution: 1400 N. Caroline St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Rosalie Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victor LeRoy Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Henrietta Hettie Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29-1891

8. AGE: Years 56 | Months 6 | Days 0 | If less than one day hr. min.

9. Birthplace New Freedom Pa. (Town, county, and state)

10. Usual Occupation self employed
11. Industry or business Painting

FATHER
12. Name Daniel Fisher
13. Birthplace Pa.

MOTHER
14. Maiden Name ✓
15. Birthplace ✓ Hattie Marie

16 (a) Informant Mrs. Henrietta Fisher
(b) Address 2919 Rosalie Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location York, Pa.

18 (a) Funeral director L. J. Lupe
(b) Address 5305 Harford Rd.

19 (a) DEC 1 - 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1947 at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/29 at 4:45 P.M.
(b) Where did injury occur? 3020 Hamilton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Painting fell from ladder

23. Signature Earl LeRoy Rogers M.D. Medical Examiner

Date signed 11/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. 057198

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Eaton & Wilkens Apts
(b) Street address ~~[illegible]~~
(c) Hospital or institution St. Agnes Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 S. Longwood St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MR. MARTIN L. White

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma I. White
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 6-19-1887

8. AGE: Years	Months	Days	If less than one day
60	5	10	— hr. — min.

9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B & O R.R.

FATHER
12. Name Thomas White
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Alice White
15. Birthplace N. Carolina

16 (a) Informant Mrs. Emma I. White
(b) Address 521 S. Longwood St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-Dec.-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director E. B. Wippert & Son
(b) Address 1300 Eutaw Place.

19 (a) 12-1-1947 (b) [illegible] Registrar
(To be filled by Registrar) Certificate for Address Filed

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29-47 1947, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28- 1947, to 11-29 1947, and that I last saw h[illegible] alive on 11-29 1947.

Immediate cause of death Cerebrovascular Accident (Hemorrhage) — Duration

Due to Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature José G. Valdenas M. D.
Address St. Agnes Hospital Date signed 11-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 657499

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave.
(c) Hospital or institution:
St Agnes Hosp. 25-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 67 Oakley Village
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Carolina Jester - "Caroline Jester"
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Roland Jester (dec)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4 1883

8. AGE: Years 64 | Months 10 | Days 25 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business At Home

FATHER
12. Name Ferdinand Koslowski
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Klamm
15. Birthplace Germany

16 (a) Informant Miss. Adelle Jester
(b) Address 2563 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-Dec 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director C. B. Wilbert + Son
(b) Address 1726 Eutaw Place

19 (a) DEC 1 - 1947 (Date rec'd by registrar) (b) Registrar Wilmington Wilkinson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1947, at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11 28 1947 to 11 29 1947, and that I last saw her alive on 11 29 1947.

Immediate cause of death Cardiac failure
H.C.V.D. - Diabetes
Mellitus - Coma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place)
While at work?
(e) Means of injury

23. Signature J. W. Mundé Jr.

Address Glayne Date signed 11/29/47 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 A

657509 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) about 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Don Aire Apts 320 Harmon Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country Brooklyn, Md.

3 (a) FULL NAME ~~Caroline Retz~~ Caroline Pauline Retz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Edward Retz

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1887

8. AGE: Years 60 | Months 9 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Russia Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Fischer
13. Birthplace Russia Poland

MOTHER 14. Maiden Name Amalia Dravitz
15. Birthplace Russia - Poland

16 (a) Informant Edward Retz (Husband)
(b) Address ~~325 Harmon Lane~~ Don Aire Apts Harmon Lane, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month, day, yr.) Dec 3 1947

(c) Cemetery or crematory Cedar Hill Location Glen Burnie, Md

18 (a) Funeral director Howard Evans
(b) Address 1400 E Chase St.

19 (a) DEC 1 1947 (Date received by local registrar) (b) Huntington Williams, M.D. Franklin Square Hosp.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Nov (Sunday) 1947, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1947 to 30 Nov 1947, and that I last saw h.W alive on 30 Nov 1947.

Immediate cause of death: Coronary occlusion — Duration: ____

Due to: Arteriosclerotic Heart disease — Duration: ____

Due to: ____ — Duration: ____

Other Conditions: Carcinoma of esophagus — Duration: ____

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M.
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature Vincent A. Cacace M. D.

Date 30 Nov 47

357501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 357501

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5th
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Forest St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Walton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	

6 (b) Name of husband or wife MARY PATUR 20
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1st 1880

8. AGE: Years	Months	Days	If less than one day
67	2	23	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation Elevator Man
11. Industry or business Mercy Hospt.

FATHER
12. Name Patrick Walton
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Quinn
15. Birthplace Ireland

16 (a) Informant Mrs G. Rosenberger
(b) Address 2504 E. Biddle St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-2-1947 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEMETERY
Location NORTH AVE EXT.

18 (a) Funeral director LEO G COOK
(b) Address 1701-02 PATTERSON PK AVE

19 (a) DEC 1 - 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1947, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helpern M.D. Medical Examiner.
Date signed Nov 29, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657502

657502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside Mayor town limits, write RURAL and give town)
(d) Street No. 820 N Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Snyder Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 83 | Months | Days | If less than one day ...hr. ...min.

9. Birthplace Germany (Town, County, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Schneider
13. Birthplace Germany.

MOTHER
14. Maiden Name Mary Bunn
15. Birthplace Germany.

16 (a) Informant Philip Frastel
(b) Address 1738 E. Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2nd 1947 (month) (day) (year)
(c) Cemetery ~~crematory~~ Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park

19 (a) DEC 1 - 1947 Huntington Williams (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1947, at 5:41 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Nov death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio Vascular
Due to Disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helbrick M.D. Medical Examiner.
Date signed Nov 29, 1947

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C57503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E

Registered No. C57503

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 234 S. Streeker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 S. Streeker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C. Morrissey

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: James P. Morrissey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16 1886

8. AGE: Years: 61 | Months: 2 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Henry O'Neil
(b) Address 234 S. Streeker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2-47 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location: Frederick Rd.

18 (a) Funeral director: Frank H. Newell
(b) Address: Pikesville, Md

19 (a) DEC 1 1947 (Date rec'd by Registrar) (b) Huntington Williamsport Pa

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1947, at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1947 to Nov 30 1947, and that I last saw h.. alive on Nov 30 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to: Lymphic Cardio Vascular Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Albert Seagmuller M. D.
Address 1724 W. Lombard St Date signed Dec 1 '47

MARGIN RESERVED FOR BINDING

(PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

657504 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution:
St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 240 West South St
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emily G. Grove

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife J. Arthur Grove

6 (c) If alive, give age Yes years

7. Birth date of deceased (mo., day, yr.) Dec 6 1906

8. AGE: Years 40 (34) | Months 11 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Willard Barthlow
13. Birthplace Md.

MOTHER
14. Maiden Name Eliz. Burke
15. Birthplace [illegible] Virginia

16 (a) Informant J. Arthur Grove
(b) Address 240 W. South St. Frederick. Md

17 (a) Burial (b) Date thereof 12-3-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Frederick - Maryland

18 (a) Funeral director C. E. Cline & Son
(b) Address Frederick - Md.

19 (a) ..... (b) .....
(Date rec'd by Registrar) Registrar

Boston for Williamsport, Md

VS (150)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1st, 1947 at 1130 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19, 1947 to Dec 1, 1947 and that I last saw her alive on Dec. 1, 1947

Immediate cause of death	Duration
Uremia	
Due to Carcinomatasis, abdominal, generalized	
Due to Adenocarcinoma, rectum	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation May 1946

Major findings of operation: Carcinoma of the Rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter J. Benander M. D.

Address St. Agnes' Hospital, Balto. Md. Date signed 12/1/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 657505

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 Calhoun St.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Daniel Watts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Harriet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1867

8. AGE: Years 80 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace St Marys County Md. (Town, county, and state)

10. Usual Occupation farmer

11. Industry or business

FATHER
12. Name Meriet Watts
13. Birthplace St Marys County Md.

MOTHER
14. Maiden Name Teresa Smallwood.
15. Birthplace St Marys County Md

16 (a) Informant Mary L. Biscoe
(b) Address 816 Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21/47 (month) (day) (year)
(c) Cemetery or crematory New Fair Cemetery
Location St. Marys County.

18 (a) Funeral director Mrs. Robt. A. Elliott & Son
(b) Address 1129 N. Gardner St.

19 (a) DEC 1 - 1947 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1947, at 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1947 to Nov 30 1947 and that I last saw h[illegible] alive on Nov 29 1947

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Senile Disease	3yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Huntington Williams M.D.
Address 1129 N. Gardner St. Date signed Dec 1 1947

657306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

657306
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 N. Pearl Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM McFARLING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 1, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 1 1947 (Signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1947, at 9 a. M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Ryan M.D.
Medical Examiner

Date signed 11-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

657507 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3023 Arunah ave.
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Arunah ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) **FULL NAME** MAUDE E. ROSENSTOCK

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 219-16-7060

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Abram Rosenstock

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1875

8. AGE: Years 72 | Months 2 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Frederick County, Md. (Town, county, and state)

10. Usual Occupation Saleswoman

11. Industry or business

FATHER
12. Name Charles H. Anders
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Margaret R. Hiteshue
15. Birthplace Littletown, Penna.

16 (a) Informant Miss Minnetta Anders
(b) Address 3023 Arunah ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director Chas J. Evans Son & Co
(b) Address 118 N. Mt. Royal Ave

19 (a) ____ (b) ____ (Date received) (Registrar)

DEC 1 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1947, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Nov 28 1947 and that I last saw her alive on Nov 28 1947.

Immediate cause of death Coronary thrombosis — Duration 3 hours

Due to Acute alveolar type heart Dis. with cardiac hypertrophy — Duration 5 years

Due to and congestive failure — Duration 4 yrs

Other Conditions generalized arteriosclerosis with hypertension.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 2901 Edmondson Date signed Nov 29 1947 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 55E

657508 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John
(c) Hospital or institution: Hosp. for Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14d
(e) Length of stay in Baltimore (yrs., mos., or days) 14d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Port Deposit (If outside city or town limits, write RURAL and give town)
(d) Street No. 39 High St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Etta Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1872

8. AGE: Years	Months	Days	If less than one day
74	11	28	hr. min.

9. Birthplace Kenosha, Wis. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Rev. Enoch Miller
13. Birthplace ? England

MOTHER
14. Maiden Name Fanny Jeffers
15. Birthplace ? England

16 (a) Informant Deceased – Hospital Records
(b) Address Hosp. for the Women of Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location North East, Cecil Co., Md.

18 (a) Funeral director E. A. Catterall & Son
(b) Address Perryville, Md.

DEC 1 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1947, at 2 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 18 1947 to Dec 1 1947, and that I last saw her alive on Dec 1 1947

Immediate cause of death	Duration
Resp Failure	
Due to Pleural effusion	
Due to Lymphosarcoma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank H. Logan M. D.
Address Lafayette & John Date signed 12-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1488

657509 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto. Md.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Havre de Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No. 667 Otsego St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth L. Bagg Mrs. 94799

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Raymond C. Bagg

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1906

8. AGE: Years 41 | Months 9 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Cecil Co. Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Wm. McFadden

13. Birthplace Penn.

MOTHER 14. Maiden Name Pearl Sampson

15. Birthplace Md.

16 (a) Informant Raymond C. Bagg

(b) Address Havre de Grace Md.

17 (a) Burial (b) Date thereof Dec. 4, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Cecil Co. Md.

18 (a) Funeral director L. Madison Mitchell

(b) Address Havre de Grace, Md.

19 (a) — 1947 (b) — Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 | 1 1947, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1947 to 12/1 1947, and that I last saw h[illegible] alive on 12/1 1947

Immediate cause of death: Respiratory failure — Duration

Due to: Cerebral edema

Due to: Hypertensive chronic nephritis

Other Conditions: Post partum — 2 weeks
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: [illegible]

of autopsy: Cerebral edema nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. S. Shelton

Address Univ. Hosp. Date signed 12/1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

057510 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 N. Harvard Ave.
(c) Hospital or institution: 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) ——
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 N. Harvard Ave.
(If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Hite Bond

3 (b) If veteran, name war ——
3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widower

6 (b) Name of husband or wife: Ada Bethel Moore
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1864

8. AGE: Years	Months	Days	If less than one day
83	1	-	hr. min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)
10. Usual Occupation Harness Maker
11. Industry or business Leather

FATHER
12. Name Cornelius Bond
13. Birthplace Maryland

MOTHER
14. Maiden Name Hannah Taylor
15. Birthplace Maryland

16 (a) Informant Mitchell H. Bond
(b) Address 1809 N. Harvard Ave. Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Mountain View
Location Union Bridge Md.

18 (a) Funeral director D. D. Hartlove & Son
(b) Address New Windsor, Md.

19 (a) Dec. 9 1947 (Date rec'd by registrar) (b) Registrar for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1947, at 1 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1947, to Dec 7 1947, and that I last saw h[illegible] M alive on Dec 7 1947.

Immediate cause of death: Myocarditis with Congestive Heart Failure — Duration 4 days
Due to: Cardio-Renal Vascular Disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. H. Wilson
Address 617 W 40th St Date signed 12/9/47

G57511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57511

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20-6
(c) Hospital or institution: South Balto. Grail Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Bernice Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Nuffer
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-03-8091

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Augusta Nuffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22nd 1889

8. AGE: Years	Months	Days	If less than one day
58	10	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Sheet Metal Mechanic
11. Employer " " Co

FATHER
12. Name John Nuffer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Nuffer
15. Birthplace Un Known

16 (a) Informant Augusta Nuffer
(b) Address 2 S. Bernice Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/4/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location Glen Burnie Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 2 - 1947 (Date rec'd by Registrar) (b) Huntington-Williams Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Nov. 1947 at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.
Date signed 2 Dec. 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

577512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. 577512

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 Carswell St
(c) Hospital or institution: 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltemore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Carswell do
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Pandolfina

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank P. Pandolfina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1878

8. AGE: Years	Months	Days	If less than one day
69	8	5	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name August De Luca
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Ruggierri
15. Birthplace Italy

16 (a) Informant Anna Pandolfina
(b) Address 1617 Carswell

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 2 - 1947 (Date rec'd by registrar) Huntington for Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1947, at 11 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1946 to Nov 30 1947, and that I last saw h[illegible] alive on Nov 30 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hrs
Due to Arterio Sclerosis	1 yr
Hypertension	1 yr
Due to Chronic Nephritis	1 yr
Other Conditions Carcinoma Left Kidney	1 yr
CARCINOMA OF LEFT KIDNEY	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J F A Stevens M. D.
Address 2818 Hartford Rd Date signed 12-1-47

1312

657513

657513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3508 Devonshire Drive
(c) Hospital or institution: 27-20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 Devonshire Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Albert William Mentzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Sarah A. Mentzel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26th 1862

8. **AGE:** Years: 85 | Months: 3 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. ~~Industry or~~ business: Paper & Printing

FATHER
12. Name: Henry D. Mentzel
13. Birthplace: Md.

MOTHER
14. Maiden Name: Elizabeth (Unknown)
15. Birthplace: Md.

16 (a) Informant: Mrs. Alberta W. Guirial
(b) Address: 3508 Devonshire Drive

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Green Mount
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul st.

19 DEC 2 - 1947 Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30th 1947, at 11.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1946 to Nov 30 1947 and that I last saw h~~im~~ alive on Nov 30 1947.

Immediate cause of death	Duration
Cancer of prostate	3/4/46
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Bubert M. D.

Address 4603 Park Heights Av Date signed 12/1/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G57314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G57514

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St.
(c) Hospital or institution: Good Samaritan Home 132
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 Callow Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Naomi R. Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry H. Sanders

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1920

8. AGE: Years 27 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Hancock Md. (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER 12. Name John Beard

13. Birthplace Unknown

MOTHER 14. Maiden Name Mary Wilson

15. Birthplace Hancock Md.

16 (a) Informant Harry H. Sanders

(b) Address 2019 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto. Md.

Location

18 (a) Funeral director Wm. Cook Inc.

(b) Address 1217 E. Fayette St.

19 (a) DEC 2 - 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1947, at 7:49 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1947, to Nov 30 1947 and that I last saw h-- alive on Nov 25 1947.

Immediate cause of death	Duration
Carcinoma of cervix	One year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Steerman M. D.

Address 553 N Fayette Date signed Nov 30 1947

G57515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied: The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey st.
(c) Hospital or institution: Good Samaritan Home 10-2
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Abbott Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry N. Clary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Edith Clary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ——

FATHER
12. Name Richard G. Clary
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Clementine V. (Unknown)
15. Birthplace Balto. Md.

16 (a) Informant Edith Clary
(b) Address 819 Abbott Court

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

DEC 2 - 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29th 1947, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1947 to Nov 29 1947, and that I last saw h alive on Nov 29 1947.

Immediate cause of death Acute Cardiac Dilatation — Duration 1 day

Due to Hypertension Cerebral Vascular — 7

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Lafayette Ave Date signed Nov 30 47

057516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

057516 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 32nd ST.
(c) Hospital or institution: Union Memorial Hosp. 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mallory Apts: E. Ext. of W. La. M.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph RING

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife Dead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/1866

8. AGE: Years	Months	Days	If less than one day
81	1	8	hr. min.

9. Birthplace Balto. Md
(City, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Moses Ring
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Engel
15. Birthplace Balto, Md.

16 (a) Informant Mrs. Ruth Ring
(b) Address Moreborough Apts.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Abram Sonneborn & Son
(b) Address 202 Eutaw Place

19 DEC 2 1947 (b) Huntington Williams, M.D.
(Registered by registrar)

VS 150 11 48 10 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Dec. 1947, at 1:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21/47 19 to 12/1/47 19, and that I last saw him alive on 12/1/47

Immediate cause of death: Myocardial Infarct — Duration 5 weeks
Due to: Arteriosclerotic Heart Disease — 30 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Myocardial infarction, Coronary heart, Arteriosclerotic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury
23. Signature Herbert Klein M.D.
Address Union Memorial Hospital Date signed 12-1-47

X

657517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87c

657517 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3701 Egerton Road.
(c) Hospital or institution: 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Egerton Road. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS ROSENSTEIN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena Rosenstein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1866.

8. AGE: Years 81 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace: Russia. (Town, county, and state)
10. Usual Occupation: Retired Merchant.
11. Industry or business

FATHER:
12. Name: Nisan Rosenstein,
13. Birthplace: Russia.

MOTHER:
14. Maiden Name: Sarah ?
15. Birthplace: Russia

16 (a) Informant: Mr. Albert Rosenstein,
(b) Address: 3701 Egerton Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/47. (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship
Location: Balto. Md.

18 (a) Funeral director: Harris Funeral Home
(b) Address: 1902 Eutaw Place.

19 DEC 2 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1st. 1947 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1935 to Dec 1 1947 and that I last saw h[illegible] alive on Dec 1 1947.

Immediate cause of death: Pharyngeal abscess (ruptured) — Duration: 10 days.
Due to:
Due to:
Other Conditions: Parkinson's disease, arteriosclerotic disease
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: Jack J. Singer M. D.
Address: 506 E. North Ave. Date signed

VS 150

115c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

657518 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave., Balto., Md.
(c) Hospital or institution:
Pine Ridge Nursing Home 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE E. PRITCHARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Emily L. Pritchard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1863

8. AGE: Years	Months	Days	If less than one day
84	9	7	hr. min.

9. Birthplace Aberdeen, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B&O R.R.

FATHER
12. Name William Pritchard
13. Birthplace Aberdeen, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Frank R. Harten
(b) Address 2713 Woodsdale Ave

17 (a) Burial (b) Date thereof Dec. 2, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Grove Presbtyn Cem.
Location Aberdeen, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves., Balto., Md.

19 DEC 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1947 19 , at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22nd. 47 to Nov. 29th. 47.
and that I last saw him alive on Nov. 29th. 19 47.

Immediate cause of death Myocardial Insufficiency — Duration about 6mos
Due to
Due to
Other Conditions Arteriosclerosis — unknown
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James W. Margetroy M.D.
Address 401 E. 25th. St. Date signed 12/2/47.

657519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 94a

Registered No. 657519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 W North Ave
(c) Hospital or institution: 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2216 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mellord R. Bunting

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Grandolyn F. J. Bunting
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 21-1878

8. AGE: Years	Months	Days	If less than one day
68	11	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business The Texas Company

FATHER
12. Name Joseph O. Bunting
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah E. Jones
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Gwendolyn F. J. Bunting
(b) Address 2216 W. North Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/47 (month) (day) (year)
(c) Cemetery or crematory Druid Cemetery
Location Baltimore County, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna Aves.

19 DEC 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29. 1947 at 1:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wilbert F. Kelbach M.D. Medical Examiner.
Date signed Nov 29, 1947

657520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59B

657520 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2411 W. North Ave
(c) Hospital or institution: 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.,
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEVIN OSCAR DORSEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Adel Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1873

8. AGE: Years	Months	Days	If less than one day
74	1	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired elevator inspector
11. Industry or business

FATHER
12. Name Robert Henry Dorsey
13. Birthplace Somerset County, Md.

MOTHER
14. Maiden Name Alice Jane Bevans
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Howard R. Sheely
(b) Address 2411 W. North Ave.

17 (a) Burial (b) Date thereof 12/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~XXXXXX~~ Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves., Balto., Md.

19 DEC 2 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1947 19 , at 2:15P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 19 47 to Nov. 29 1947, and that I last saw h[illegible] alive on Nov. 29 19 47

Immediate cause of death	Duration
Cardiac Failure	2 days
Due to Generalized Arteriosclerosis	?
Due to	
Other Conditions Hypertrophic Arthritis	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Philip F. Lerner
Address 2401 W. North Ave Date signed 12/1/47

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657521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. 657521

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 EDGEWOOD ST.
(c) Hospital or institution: 15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 EDGEWOOD ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET B. STALEY

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband or wife: DANIEL H. STALEY
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JAN. 9, 1857
8. AGE: Years 90 | Months 10 11 | Days 22 23 | If less than one day hr. min.
9. Birthplace HAGERSTOWN, MD.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name JAMES BOOTH
13. Birthplace MD.

MOTHER
14. Maiden Name ELIZABETH M. SCHNEBLEY
15. Birthplace MD.

16 (a) Informant MR. D. LEE STALEY (SON)
(b) Address 129 SUMMIT AVE; HAGERSTOWN, MD
17 (a) BURIAL (b) Date thereof 12/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. MARGARETS EPISCOPAL CHURCH,
Location WASH. CO. MD
18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address NORTH & PA. AVE; BALTO, MD.
19 (a) DEC 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 1 1947, at 4:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 27 1947, to NOV 30 1947, and that I last saw [illegible] alive on NOV 30 1947.

Immediate cause of death: Acute cardiac Dilatation — Duration
Due to: age
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: [signature] M. D.
Address Westminster, Md. Date signed Dec 1 '47

VS 150

7522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 657522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital 91
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Yolando Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH ELIZABETH MULLINEAUX (HILTON)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. NO.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M MULLINEAUX
6 (b) Name of husband or wife: WALTER PINKNEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/29/72

8. AGE: Years 75 | Months 7 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Howard County. MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business NONE

FATHER
12. Name JAMES HILTON
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah E. Mullineaux
15. Birthplace Maryland

16 (a) Informant Husband
(b) Address 3804 Yolando Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director M. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto. Md.

19 DEC 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1 1947, at 1.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17/ 1947 to 12/1 1947, and that I last saw her alive on 12/1 1947.

Immediate cause of death	Duration
UREMIA	
Due to NEPHROSCLEROSIS	
Due to ARTERIOSCLEROSIS - HYPERTENSIVE CARDIO-VASC. DISEASE	
Other Conditions DIABETES MELLITUS	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry J. Houska M.D.
Address [illegible] Date signed 12/4/47

VS 190

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57

657523 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street 18-3
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 South Arlington Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. GRACE M. THACKER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mr Wm Thacker.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1893

8. AGE: Years 54 | Months 6 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Charles Tarbutton
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Wilson
15. Birthplace Md

16 (a) Informant Husband
(b) Address same

17 (a) Burial (b) Date thereof 12/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2930 Frederick Ave

18 (a) Funeral director John J. Coogan & Son
(b) Address 907-03 Hollins St.

19 DEC 2 1947 (Signature) Huntington Williams M.D.
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1947, at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8-1947 to 12-1-1947, and that I last saw her alive on 12-1-1947.

Immediate cause of death Bronchopneumonia — Duration 5 days

Due to ____

Due to ____

Other Conditions Spinal cord tumor — Duration 6 mos.
(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation ____

of autopsy ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature Charles E. MacDonald M. D.
Address 1213 Light St. Date signed 12-1-47.

X

657524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 657524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 Hollins St.
(c) Hospital or institution: 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 906 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph DeDresbach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20th 1864

8. AGE: Years 83 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Theater Mgr

FATHER
12. Name William Dresbach
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Unknown
15. Birthplace Germany

16 (a) Informant Miss Lottie Dresbach
(b) Address 906 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.
Location 4480 Belair Rd.

18 (a) Funeral director John F. Cowan & Son
(b) Address 901-05 Hollins St.

DEC 2nd 1947 (Date rec'd by registrar) per Victor Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1st 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1947, to 19, and that I last saw h alive on Nov 30 1947.

Immediate cause of death: Mitral Condition Chr. — Duration: 4 years

Due to: Old age

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Lamond M. D.

Address 9 Cou. Lombard St. Date signed Dec. 1947.

657325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

657325 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1041 Sharp St
(c) Hospital or institution: 23

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1041 Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Croffard + Crawford

3 (b) If veteran, name war S. A. | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	c	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/11/1855

8. AGE: Years	Months	Days	If less than one day
62	10	17	hr. min.

9. Birthplace Asheville N. C. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Janie Brantman
15. Birthplace unknown

16 (a) Informant Janie Boone
(b) Address 1039 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/47 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director Isaiah T. Brown & Son
(b) Address 108 W Montgomery St

1947 DEC 2 - (Date rec'd by registrar) Courtesy for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29/ 1947 at 4 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1947 to Nov 28 1947 and that I last saw him alive on Nov 27 1947

Immediate cause of death Chronic Myocarditis — Duration Unknown
Due to unknown
Due to
Other Conditions none
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert W. Jaines M. D.
Address 501 W. Hamburg St Date signed 12/1/47

VS 150

657526

LW 114079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. 657526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 23-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 901 Bevan St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Hardin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24- 1903

8. AGE: Years 44 | Months 1 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Hardin

13. Birthplace N.C.

MOTHER

14. Maiden Name Annie Murrell

15. Birthplace N.C.

16 (a) Informant B.C.H.Records

(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof 12/3/47 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory [illegible]

Location Newbern N.C.

18 (a) Funeral director Isaiah L Brown Jr

(b) Address 06 W Montgomery St

19 (a) Dec 3 1947 (b) Huntington Williams MD (Date signed by) (Title)

VS 150 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1947, at 9:05P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1947 to Nov. 29 1947, and that I last saw him alive on Nov. 29- 1947.

Immediate cause of death Rheu. e-v Disease. — Duration

Due to

Due to

Other Conditions Calcification of Aortic valve, Pulmonary Edema. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: See above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herbert R. Fowler M. D.

Address Balto. City Hosp. Date signed 12-1-47

X

657527.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46E

657527 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Wilker av. (14)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Klass
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1871

8. AGE: Years	Months	Days	If less than one day
76	5	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name George Klass
FATHER 13. Birthplace Germany
MOTHER 14. Maiden Name Wilhelmina Dill
MOTHER 15. Birthplace Germany

16 (a) Informant Mrs. J.W. Klass
(b) Address 2201 Wilker Ave.,

17 (a) burial (b) Date thereof 12/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lasch Funeral Homes
(b) Address 7401 Belair Rd.

19 DEC 2 1947 (b) Huntington Williams M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1- 1947 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12- 1947 to 12- 1947 and that I last saw h[illegible] alive on 12-1 1947

Immediate cause of death Pulmonary edema — Duration
Due to Hemorrhage in bowel (possible)
Due to Possible malig- nancy of bowel
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C.B. Pearre M. D.
Address Univ. Hosp. Date signed 12-1-47

X

657528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

657528 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days): 30 days
(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 3802 Hickory Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Walter F. Fisher

3 (b) If veteran, name war: WWI

3 (c) Social Security Account No.: 213-01-0461

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Georgianna Mann
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Aug. 25, 1892

8. AGE: Years	Months	Days	If less than one day
55	3	5	....hr. ....min.

9. Birthplace: Portersville, Md.
(Town, county, and state)
10. Usual Occupation: Electrician
11. Industry or business:

FATHER
12. Name: James Fisher
13. Birthplace: Md.

MOTHER
14. Maiden Name: Minnie ?
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 3/47 (month) (day) (year)
(c) Cemetery or crematory: New National
Location: Ingleside Road

18 (a) Funeral director: Ehrenwerth & Donovan
(b) Address: 2615-17 Chestnut Ave Huntington Williams, Md

19 (a) DEC (Date received by Registrar) 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30, 1947, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 1947 to Nov. 30 1947, and that I last saw him alive on Nov. 30 1947.

Immediate cause of death	Duration
(1) Nephritis, type undetermined, marked	
(2) Cardiac hypertrophy, marked	
~~Due to~~ (3) Arteriosclerosis generalized, moderate	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 12/1/47

X

(657529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. 657529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 941 Etting st
(c) Hospital or institution: 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 941 Etting (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leticia Gray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 67 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Joshua Waters
13. Birthplace Md

MOTHER 14. Maiden Name Lettie ?
15. Birthplace Md

16 (a) Informant Maggie Rhys
(b) Address 941 Etting st

17 (a) Burial (b) Date thereof 12/4/39
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Rd.

18 (a) Funeral director J. Hyland
(b) Address 918 Druid Hill Ave.

19 (c) DEC 2 1939 (b) Huntington for Williams M.D.
(Date rec'd by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1939 at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1939 to Nov 28 1939 and that I last saw h[illegible] alive on Nov 28 1939

Immediate cause of death	Duration
Arteriosclerosis	
Cardiac Decomp.	1 yr.
Due to Diabetes	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed 12-4-39

G57530

BALTIMORE CITY HEALTH DEPARTMENT

GM. 115491 CERTIFICATE OF DEATH ✓ 87E

Registered No. G57530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 O'Donnell ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Kucharski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Felix

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April - 6 - 1894

8. AGE: Years 53 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alexander Pietraski
13. Birthplace Poland

MOTHER 14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-4-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Wandalk ave

18 (a) Funeral director John J. Kuda
(b) Address 2829 Hudson st

19 DEC 2 1947 (Date received by Registrar) (b) Huntington Williamson W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 - 1947, at 11.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26- 1947 to Nov. 30 - 1947 and that I last saw h. or alive on Nov. 30 - 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Possible brain tumor	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/30/47

Major findings of operation: Increased intracranial pressure

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. N. Crosby M. D.

Address Date signed

057531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 057531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 Oakley ave
(c) Hospital or institution: 2711

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Oakley ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Munz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mrs Mary Caplan
(b) Address 2905 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herzuna Linc

18 (a) Funeral director Jack Kevitz Inc
(b) Address 2100 Eutaw Place

19 Dec 2 1947 (Signature of registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1 1947, at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to 11/30 1947, and that I last saw h[illegible] alive on 11/3 1947.

Immediate cause of death: Coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Chidecker M.D.

Address 2225 Linden Ave Date signed 12/1/47

657532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √61

657532 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 E. Balto St
(c) Hospital or institution: 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hyman Dvorianskey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name William
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Sarah Dvorianskey
(b) Address 1713 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew-Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 DEC 2- 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1- 1947, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24-46 19 to 12-1- 1947, and that I last saw him alive on 12-1- 1947.

Immediate cause of death	Duration
Coronary Occlusion	Immediate
Due to Arteriosclerosis	
Due to Nephritis - Diabetes Obesity	
Other Conditions Pulmonary Congestion	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Linden M. D.
Address 14 S. Broadway Date signed 12/2/47

657533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162B

Registered No. 657533

Every item of information should be carefully supplied. Typewrite or write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Typewrite or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3040 WINDSOR AVE
(c) Hospital or institution: — 157
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3040 WINDSOR AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: MARY ESTELLE CLOSE

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband ~~or wife~~: ALBERT BIGGS CLOSE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 29, 1857

8. AGE: Years 90 | Months 4 | Days 2 3 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name ELDRIDGE F. KRIBE

13. Birthplace MARYLAND

MOTHER 14. Maiden Name VIRGINIA G. MORRISON

15. Birthplace MARYLAND

16 (a) Informant MR. HERBERT E. CLOSE JR. (Son)

(b) Address 3040 WINDSOR AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)

(c) Cemetery or ~~crematory~~ DRUID RIDGE CEM

Location PIKESVILLE, (BALTO COUNTY) MD.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address NORTH & PA. AVES. BALTO, MD.

19 DEC 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 1, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to Dec 1st 1947, and that I last saw h~~e~~r alive on Dec 1 1947.

Immediate cause of death	Duration
Uremia	
Due to Broken Hip and Senility	11 Mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence April 1946 at 7 M
(c) Where did injury occur? North Ave & Rosedale (City or town) Balto (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury Fell Downstairs while walking

23. Signature Howard J. Meredith M.D.

Address 3033 W North Ave Date signed 12/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 657534

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 W. North Ave.
(c) Hospital or institution: 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUTH EVELYN BUCKLER

3 (b) If veteran, name war: No e
3 (c) Social Security Account No.: None

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: James I. Buckler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1894

8. AGE: Years 53 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John H. Pritchett
13. Birthplace Wales

MOTHER
14. Maiden Name Nona Carter
15. Birthplace Virginia

16 (a) Informant Mr. James I. Buckler
(b) Address 2024 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves., Baltimore

19 (a) [illegible] (Local Registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1947 19 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 19 41 to Nov 30 19 47 and that I last saw h[illegible] alive on Nov 29 19 47

	Duration
Immediate cause of death: Coronary Thrombosis	2 hrs.
Due to: Arteriosclerotic Cardio-renal Disease	2 yrs.
Due to: Essential Hypertension	3 yrs.
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Strachan M.D.
Address 2302 Edmondson Ave Date signed 12/1/47
M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 58535

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2553 - McHenry St.
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2553 - Mc. Henry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Irvin Cole.

3 (b) If veteran, name war: none.
3 (c) Social Security Account No.: none.

4. Sex: Male
5. Color or race: White.
6 (a) Single, married, widowed, or divorced: Widowed.
6 (b) Name of husband or wife: Anna M. Cole
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20-1880

8. AGE: Years 67 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Engineer.
11. Industry or business B. & O. R. R.

FATHER
12. Name Unknown.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown
15. Birthplace Penna.

16 (a) Informant Mrs. Pauline L. Young.
(b) Address 3907 - Woodley Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Dec. 3-47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location

18 (a) Funeral director Charles J. Schwab
(b) Address 3512 Frederick, Ave.

19 DEC 2 - 1947 (Date rec'd by registrar) Hampton Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November, 29. 1947. at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1947 to Nov 29 1947 and that I last saw him alive on Nov 29 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to: Hypertensive Cardiovascular Renal Disease	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred Cole M. D.
Address 1934 Wilkens Ave. Date signed 12-1-47

X

057536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 057536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 Linnard St.
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Linnard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olive Smith Ford

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Widow

6 (b) Name of husband or wife late Frederick D. Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1860

8. AGE: Years	Months	Days	If less than one day
87	8	9	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Smith
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Rev. Dr. E. M. McCauley
(b) Address 605 Linnard St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 2/47 (month) (day) (year)
(c) Cemetery or crematory East Hill
Location Salem, Va.

18 (a) Funeral director Harry H. Nuttle
(b) Address 4101 Edmondson Ave.

19 DEC 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address 605 E. Edmondson Ave.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1/47 19 , at 12.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Dec 1 1947 and that I last saw h alive on Nov 30 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	5 days
Due to Arterio-Sclerotic Heart disease	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. P. Vandeburg M.D.
M. D.
Address 605 E. Edmondson Ave. Date signed 12/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1573537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. 1573537

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 S. Hilton St.
(c) Hospital or institution: 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 9 S. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George M. Schnepf

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-5632

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife Carrie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22 1886

8. AGE: Years 61 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Arundel Corp. S&G

FATHER: 12. Name John G. Schnepf
13. Birthplace ?

MOTHER: 14. Maiden Name Priscilla
15. Birthplace ?

16 (a) Informant Carrie Schnepf
(b) Address 9 S. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec/ 3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Ave (Balt. Md.)

18 (a) Funeral director Grand Dalla Rose
(b) Address 52 N. Morley St.

19 (a) DEC 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1947, at 11 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1946 to Nov. 29 1947, and that I last saw h. alive on Nov. 29 1947

Immediate cause of death	Duration
Mitral Insufficiency	
Due to	
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton Sapperstein M. D.
Address 721 E. Lanvale St. Date signed 12/1/47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 57538

57538 B.C.C 81929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Provident Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Dolphin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Yvonne Evans

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/11/47

8. AGE: Years	Months	Days	If less than one day
	5	19	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Theodore Evans
13. Birthplace N.C.

MOTHER
14. Maiden Name Helen Bates
15. Birthplace Md.

16 (a) Informant Theodore Evans
(b) Address 637 Dolphin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1363 Pennsylvania Ave

DEC 2- 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Nov, 1947, at 4:55 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Whooping Cough

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kramer Jr. M.D. Medical Examiner.
Date signed 1 Dec. 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1111B

Registered No. 057539

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-5
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 1817 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Black

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 42 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace N. C (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs Daisy Patterson

(b) Address 113 W. 22nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 2 47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location R. C. Co

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 DEC 2 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1947 (month) (day) (year) M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Acute Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ at ____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? ____ What at work?

(d) Means of injury

23. Signature William J. Fitch M.D. (Medical Examiner.)

Date signed Nov 29, 1947

VS 131

057540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 057540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1319 N. Broadway
(c) Hospital or institution: 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR ELBERT BALLENTINE

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 231-28-2488

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha Agnes

6 (c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1904

8. AGE: Years 43 | Months 1 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Medical Technician

11. Industry or business

FATHER
12. Name: Clarence Ballentine
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Margaret E. Lenning
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Bertha Ballentine
(b) Address: 1319 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date received) DEC 2 1947 (b) Registrar: Twittington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Nov. 29, 1947, at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1947 to 29 Nov 1947 and that I last saw h[illegible] alive on 29 Nov 1947

Immediate cause of death: Coronary Thrombosis — Duration: 8 days.

Due to: Cardio-Vascular renal Disease

Due to:

Other Conditions: Asthma, Diabetes

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Samuel Schaufele M. D.
Address: 714 E. Preston Date signed 1 Dec 47

1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(57541

AB-113195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1130

Registered No. 1557541

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 3-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1144 E. Lombard St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME: Leroy Dean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Evelyn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2- 1910

8. AGE: Years 37 | Months 8 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Walter
13. Birthplace Md.

MOTHER
14. Maiden Name Leona Wilson
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec 4, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Penn

Location Baltimore Md

18 (a) Funeral director Thos J. Wilson

(b) Address 1010 Bentley ave

19 DEC 2- 1947 (b) Kathryn Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1947, at 9.15AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21- 1947 to 11-30- 1947, and that I last saw h. in alive on 11-30- 1947.

Immediate cause of death: Tuberculosis of Lungs Bilateral & Laryngitis — Duration: 2yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Leigh W. Parks M. D.

Address Balt City Hosp Date signed 12-1-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 931

657542 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins 3-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 E. Lombard St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Eliza Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex f | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 53 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace New Orleans (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Hennit Smith
(b) Address 909 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1099 Bloomfield ave

19 (a) DEC 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30/47 19..... at 7:20 A.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature John L. Weaver M.D.
Medical Examiner.
Date signed 11/30/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657543
BC-C92781

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
106a

657543
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 20-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2613- Dulaney St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL STANLEY McCLUNG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19 1947

8. AGE: Years	Months	Days	If less than one day
	1	15 14	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Herbert McClung
13. Birthplace Va

MOTHER
14. Maiden Name Stella Mysanek
15. Birthplace Baltimore

16 (a) Informant Stella McClung
(b) Address 2613 Dulaney St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Dead of Mary
Location Baltimore

18 (a) Funeral director Fred W Ozanowski
(b) Address 1930 Eastern Ave Balto Md

19 DEC 2 1947 (Date rec'd by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1947, at 10.35 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Upper respiratory infection
Acute tracheobronchitis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12-2-47

657544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 657544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1036 Braddock Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Allegany Grove
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Isabelle Martin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. ~~65~~ | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John J. Martin

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 9/3/1882

8. AGE: Years 65 | Months 2 | Days 30 | If less than one day ____ hr. ____ min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morton Patterson
13. Birthplace New York State

MOTHER 14. Maiden Name Barbara E. Bigam
15. Birthplace Fayette Co. Pa

16 (a) Informant John Martin
(b) Address Cumberland Md.

17 (a) Removal (b) Date thereof DEC 3-37
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Frostburg Md
Location Maryland

18 (a) Funeral director Deviney Cook & Son
(b) Address 217 St. Paul Street

19 DEC 2- 1937 Huntington for Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1937, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1937 to 12/2 1937, and that I last saw h-- alive on 11/2 1937

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to: Cardio Vascular Disease	4 yrs
Other Conditions: Ac. Bronchitis	6 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. MacMurray M. D.
Address 801 Bureau St Date signed 12/2/37

12/3/37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 13B

G57545 (Registered No.) G57545

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elliott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. College Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Stamey

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No. 244-28-0935

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Emma Bottle Stamey
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) May 14, 1916

8. AGE: Years	Months	Days	If less than one day
31	6	18	..... hr. ..... min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Donut Packer
11. Industry or business

FATHER
12. Name James Stamey
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Sally Pratt
15. Birthplace N. Carolina

16 (a) Informant Wife-Mrs. E.E. Stamey
(b) Address Elliott City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Taylor Family Cemetery
Location Ellicott City, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

DEC 2 - 1947 (Date rec'd by registrar) (b) Funeral Director Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1947, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1947, to 12-2 1947, that I last saw him alive on 12-1 1947.

Immediate cause of death	Duration
Tuberculous Meningitis	
Miliary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert B. Edmunds M. D.
Address Sydenham Hosp. Date signed 12-2-47

V S 150

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

657546 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County.....
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Somerset Place. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME WILLIAM MORRISON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7/14/1894

8. AGE: Years 53 | Months 4 | Days 18 | If less than one day .....hr. .....min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Penn. Railroad
FATHER 12. Name Wm. R. Morrison Sr.
FATHER 13. Birthplace Washington D.C.
MOTHER 14. Maiden Name —
MOTHER 15. Birthplace —

16 (a) Informant.....
(b) Address.....
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/2/47 (month) (day) (year)
(c) Cemetery or crematory.....
Location Washington D.C.
18 (a) Funeral director Wm. A. F. Hines
(b) Address 2701 14th St. N.W. Wash. D.C.
19 (a) DEC 2 - 1947 (Filed by registrar) (Washington, Nottingham, Md.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1947, at 12.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Cirrhosis of liver
Rupture of esophageal varices,
Due to with massive hemorrhage
into stomach.
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12-2-47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7547
A5-8063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. G57547

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich (b) County
(c) City or town Albion.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 3 Albion
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Hubbard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: to-19-

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-19-47

8. AGE: Years | Months: 6 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Mich.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Eugene Hubbard
13. Birthplace: Mich.

MOTHER 14. Maiden Name: Vanessa Chase
15. Birthplace: Mich.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4 47 (month) (day) (year)

(c) Cemetery or crematory Albion.
Location Albion - Michigan

18 (a) Funeral director Thomas F. Kemp Sons
(b) Address Hollins & Fulmor Sts

19 (a) [illegible] 1947 (b) Huntington Williamsville
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. - 1 - 1947 at 10 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3- 1947 to 12-1- 1947 and that I last saw h er alive on 12-1- 1947

Immediate cause of death: Congenital Atresia of the Bile Ducts — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 27 Nov 47

Major findings of operation: Complete Absence of Bile Ducts

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. H. Sachs, M.D.
M. D.

Address Johns Hopkins Hospital Date signed 2 Dec 47

X

057548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 057528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 hight Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 E. Clement Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Alverta V. Baumgart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William Baumgart
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 8 1897

8. AGE: Years	Months	Days	If less than one day
50		22 23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Lowry
13. Birthplace Maryland

MOTHER
14. Maiden Name Benner
15. Birthplace Maryland

16 (a) Informant Family
(b) Address 130 E. Fort Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-4-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md.

18 (a) Funeral director James L. McCurdy
(b) Address 130 E. Fort Ave.

19 Dec 3 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 1947, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1947, to 12/1 1947, and that I last saw h&r alive on 12/1 1947.

Immediate cause of death Coronary occlusion — Duration 8 hrs
Due to Coronary atherosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dellinger M. D.
Address South Balto Gen Hosp Date signed 12/1/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 657549

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rock Run Ave.
(c) Hospital or institution: Edgeleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Bucks.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 51 E. Randall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gustave Porst PORST

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	M.

6 (b) Name of husband or wife Mary E. C. Porst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-14-1869

8. AGE: Years	Months	Days	If less than one day
77	11	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Storekeeper
11. Industry or business Own

FATHER
12. Name Unknown Porst.
13. Birthplace Germany.

MOTHER
14. Maiden Name Mary Ganz
15. Birthplace Germany

16 (a) Informant Family
(b) Address 51 E. Randall St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-3-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director James L. McCauley
(b) Address 130 E. Fort Ave.

19 (Date rec'd by registrar) DEC 3 - 1947 (Signature) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30/1947 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947 to Nov. 30 1947 and that I last saw h[illegible] alive on Nov 30, 1947

Immediate cause of death	Duration
Cardiac decompensation,	2 days
Due to Senile Myocarditis	1 yr.
Due to Arteriosclerosis	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. Hawkins M.D.
Address 130 E. Randall St Date signed 12/4/47

X

657550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B Registered No. 657550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green St 512
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 N Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Burtnick, Sadie (BAUSK)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph

13. Birthplace Russia

MOTHER 14. Maiden Name Day

15. Birthplace Russia

16 (a) Informant Sidney Burtnick

(b) Address 1649 N Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-47 (month) (day) (year)

(c) Cemetery or crematory

Location Herzl Friendship

18 (a) Funeral director Jack Lewis Inc

(b) Address 2600 Eutaw Place

DEC (a) 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1947, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1947 to 12/2 1947 and that I last saw h. alive on 12/2 1947

Immediate cause of death Respiratory Failure — Duration

Due to Uremia

Due to Adynamic Ileus — Cause undetermined

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury,
23. Signature [signature] M. D.
Address Univ. Hosp. Date signed 12/2/47

X.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please correct age is especially important.

657551

BALTIMORE CITY HEALTH DEPARTMENT ✓ 657551 Registered No.

CERTIFICATE OF DEATH 92B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp 155
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2607 Liberty Hgts Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Sachs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, County, and State)

10. Usual Occupation merchant

11. Industry or business

FATHER
12. Name Michael
13. Birthplace Russia

MOTHER
14. Maiden Name Hattie
15. Birthplace Russia

16 (a) Informant Esther Sachs
(b) Address 2607 Liberty Hgts Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-47 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jos. Lewis Inc
(b) Address 2660 Eutaw Place

DEC 3 1947 (Date Rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1947 to 12-2 1947, and that I last saw h- alive on 12-2 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to mitral stenosis, aortic stenosis,	
Due to Rheumatic heart disease	
Other Conditions anemia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. T. Weitzman M.D.
Address Sinai Hosp Date signed 12-3-47

X

657552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 657552 Registered No. 15E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Pittsburg (If outside city or town limits, write RURAL and give town)
(d) Street No 1356 Denniston Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sherry Lynne Weisburg

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-10-47

8. AGE: Years	Months	Days	If less than one day
1 yr.	4	22	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Matthew Weisburg
13. Birthplace Pa.
MOTHER 14. Maiden Name Marian Lerton
15. Birthplace Pa.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location
18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place
DEC 2 1947 (Date rec'd by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1947 at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1947 to 12-2 1947 and that I last saw h. alive on 12-2 1947

Immediate cause of death	Duration
Hemorrhagic Shock during operation	10 min
Due to Congenital Heart Disease	16 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12-2-47
Major findings of operation: Small patency artery, Dyskarditis
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. L. and C. Cla
Address Johns Hopkins Hosp Date signed 12-2-47 M. D.

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 657553

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2820 W. Garrison Ave.
(c) Hospital or institution: 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 W. Garrison ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH B. MONEN

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-18-0495

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Charlotte Monen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 8, 1896

8. AGE: Years	Months	Days	If less than one day
51	8	25	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Cleaning Dyeing
11. Industry or business

FATHER
12. Name Bernard Monen
13. Birthplace Russia

MOTHER
14. Maiden Name Judith Meneshkin
15. Birthplace Russia

16 (a) Informant Charlotte Monen
(b) Address 2820 W. Garrison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location Hamilton ave & Philia Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 DEC 3 1947 (Date rec'd by registrar) Wilhelmina M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 2 1947, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1947 to Dec 2 1947 and that I last saw him alive on Dec. 2 1947

Immediate cause of death Coronary Thrombosis — Duration 7 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manuel Levin
Address 4818 Reisterstown Rd Date signed Dec 2/47 M. D.

V S 150

657554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 657554

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Chapel Gate Lane
(c) Hospital or institution: Pinecrest Sanitarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick H. Greaver

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7. 1872

8. AGE: Years	Months	Days	If less than one day
75	2	24	hr. min.

9. Birthplace Baltimore
(Town, county and state)

10. Usual Occupation Retired - Chemist

11. Industry or business Sharp & Dohme

FATHER
12. Name Charles H. Greaver
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Nehrmann
15. Birthplace Baltimore Md

16 (a) Informant Lottie N. Greaver
(b) Address 3019 Windsor Ave

17 (a) Burial (b) Date thereof Dec. 4 - 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Wm. & Jno. W. Teufel & Son
(b) Address 511 Edmondson Ave

19 DEC 3 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Nov 1947 to 1 Dec 1947, and that I last saw him alive on Dec 1 1947

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic heart disease	years
Due to Arteriosclerosis, generalized	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emil H. Hemming Jr M. D.
Address 4580 Edmondson Ave Date signed 2 Dec 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(57555)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 57555

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 Gwynn Ave
(c) Hospital or institution: 20-7
(d) Length of stay in hospital or institution (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Gwynn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carmella Marsiglia

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Anthony
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Marsiglia
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Giardina
15. Birthplace Italy

16 (a) Informant Rosemary Dispoto
(b) Address 351 Gwynn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director Joseph Fanaro Inc
(b) Address 20 E Lexington St

19 DEC 3 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1947 at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1947 to Dec. 2 1947 and that I last saw h[illegible] alive on Dec. 2 1947.

	Duration
Immediate cause of death: Acute myocarditis	
Due to: Chronic interstitial Nephritis	46 days
Due to: Uremia	
Other Conditions: hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles S Mustard M. D.
Address 1730 Linden Ave Date signed Dec. 2/47

7558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. 657.56

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. County
(c) City or town Fullerton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Joppa Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY J. MYERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 32 | Months | Days | If less than one day hr. min.

9. Birthplace Balt Co
(Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
12. Name Wm Joseph Myers
13. Birthplace Baltimore Co

MOTHER
14. Maiden Name Anna Jerat
15. Birthplace Baltimo Co

16 (a) Informant Anna Myers
(b) Address Joppa Road

17 (a) Burial (b) Date thereof Dec 6 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dant Josephs
Location Baltimo Co

18 (a) Funeral director [illegible] Funeral Home
(b) Address 7401 Belair Rd.

19 (a) DEC 3 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1947, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Suffocation by hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-1-47 at 12.10 p. M.
(b) Where did injury occur? Police cell- Central Dist Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Jail While at work? No
(d) Means of injury Hung self- sleeve of shirt.

23. Signature [illegible] G. Merrill M.D.
Medical Examiner.
Date signed 12-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 057557

The correct age is especially important. Physicians: please write the ... every item of information should be carefully supplied. ... to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 S. Streeper St.
(c) Hospital or institution: NONE 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 S. Streeper St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country — — —

3 (a) FULL NAME Elizabeth Lightner

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Wm. Lightner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-1858

8. AGE: Years	Months	Days	If less than one day
89	8	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Frank Grill
13. Birthplace Germany

MOTHER
14. Maiden Name Anna ?
15. Birthplace Germany

16 (a) Informant Elizabeth Weltzenbach
(b) Address 2611 Hillcrest Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

DEC 3- 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1947, at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Dec. 1 1947 and that I last saw [illegible] alive on Nov. 30 1947

Immediate cause of death	Duration
Acute Coronary Occlusion	days
Due to Coronary Arteriosclerosis — Generalized Arteriosclerosis & Hypertension	?
Due to	
Other Conditions Menere's Disease	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Carl J. Zeiler
Address 700 E. Pratt St. Date signed 12/4/47

X

657358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

657358 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Wilmot Court
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Wilmot Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Theresa Pruitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, ~~widowed, or~~ divorced: Married

6 (b) Name of husband ~~or wife~~: Andrew Pruitt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2nd 1889

8. AGE: Years 59 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md.
(City, county, and state)

10. Usual Occupation Housewife (Never Employed)

11. Industry or business Housework

FATHER: 12. Name John (Nicholas) Koerner

13. Birthplace Germany (Balto. Md.)

MOTHER: 14. Maiden Name Wilhelmina (Hattie Burress) Siljacks

15. Birthplace Germany (Balto. Md.)

16 (a) Informant [illegible]

(b) Address 1000 Wilmot Court (586 N. Fremont)

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/3/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Loudon Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 DEC 3 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1st 1947, at 1:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Dec 1ST 1947 and that I last saw HER alive on Nov 30 1947.

Immediate cause of death: Bronchogenic Carcinoma Rt Lung — Duration: 6-7 months

Due to: Massive Collapse

Due to:

Other Conditions: Rt Lung

(Include pregnancy within 3 months of death)

Date of operation: Cyt, Hyst Cabinet Sept 1947

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex A Weinstock M. D.

Address 4603 Park Ave Date signed 12/2/47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 657559

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 446 East 20th Street
(c) Hospital or institution: 17-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 446 East 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Eugene Livingston

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-4341

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Elizabeth Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17th 1889

8. AGE: Years 58 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace Pottsville Pa
(Town, county, and state)

10. Usual Occupation Time Keeper

11. Industry or business Reid Avery Co.

FATHER
12. Name Samuel Livingston
13. Birthplace Pottsville Pa.

MOTHER
14. Maiden Name Katherine Mathis
15. Birthplace New Gretna, N.J.

16 (a) Informant Elizabeth Mary Livingston
(b) Address 446 E. 20th St.

17 (a) Burial (b) Date thereof 12/5/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 3 1947 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION 35

20. DATE OF DEATH December 2, 1947 at 11 A.M.

21. I certify that I took charge of the remains described above, held an ~~Inspection~~ & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage,

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-2-47

57560 ✓ 057560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland S.V.
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 586 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes PERDIEU

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Walter Perdieu

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1918

8. AGE: Years 29 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER
12. Name Nicholas Herzing
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Nellie Burries
15. Birthplace Baltimore, Md.

16 (a) Informant Walter Perdieu
(b) Address 586 N. Gay St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Cathedral
Location Balto. Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 3 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1947, at 5:30 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11/29/47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WRITE UNFADING INK.

561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. 657561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home + Hospital
(c) Hospital or institution: Broadway + Fairmount Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 Chelsea Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Sylvester Adams

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Adams, Mrs Doanville
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1856

8. AGE: Years 91 | Months 6 | Days 25 | If less than one day: 2 hr. 20 min.

9. Birthplace: Iowa (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Wm. Adams
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Sarah Crabbe
15. Birthplace: Pa.

16 (a) Informant: Miss Georgian Adams
(b) Address: 2713 Chelsea Terrace

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Wyuka
Location: Lincoln, Nebraska

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 DEC 3 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1947, at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1947 to Dec. 2 1947, and that I last saw him alive on Dec. 1 1947.

Immediate cause of death	Duration
Myocardial insufficiency	1½ mo.
following Emaciation	
due to Of Cellular tumor	
Due to	
Other Conditions Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. Robert Haase M. D.
Address: Church Home + Hosp. Date signed 12/2/47

X

657562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V93c

Registered No. 657562

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2919 Windsor Ave
(c) Hospital or institution: 15-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Alvin Joyce

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Verna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 12, 1883

8. AGE: Years	Months	Days	If less than one day
64	2	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Maintenance Dep't
11. Industry or business C. & P. Tel. Co.

FATHER
12. Name Robert B. Joyce
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Seifer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Robert A. Joyce
(b) Address 2919 Windsor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

DEC 3 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1947, at 7:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1947, to Dec 2 1947, and that I last saw him alive on Dec 2 1947

Immediate cause of death	Duration
Cerebral Embolism	3 hrs?
Due to Valvular Cardio vascular disease	?
Due to Rheumatic Cardio vascular disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel R. Robertson M. D.
Address 2835 Guilford Ave Date signed 12/13/47

X

G57563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓1623

G57563 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2143 W/ North Ave.
(c) Hospital or institution: 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2143 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Isaac McDermit

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Male	White	Married

6 (b) Name of husband or wife Cora May McDermit
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1862

8. AGE: Years	Months	Days	If less than one day
85	1	12	hr. min.

9. Birthplace Washington, Co. Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Self

FATHER
12. Name ? McDermit
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Mary Mulligan
(b) Address 2143 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Co. Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

DEC 3 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION 10

20. DATE OF DEATH Dec. 1, 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1947 to Dec 1 1947, and that I last saw h[illegible] alive on Dec 1 1947

Immediate cause of death	Duration
Senility	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm. H. Patterson M. D.
Address 2324 Reisterstown Rd. Date signed 12/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 037564

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Light & Redwood St.
(c) Hospital or institution: 1St National Bank Building 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts Charles & 31st Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Dickson

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ollie K. Dickson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1869

8. AGE: Years	Months	Days	If less than one day
78	1	2 3	hr. min.

9. Birthplace Lansingburg, N. Y.
(Town, county, and state)
10. Usual Occupation Retired Chemist
11. Industry or business Sharpe & Lohme Dohme

FATHER
12. Name Dickson
13. Birthplace N. Y.

MOTHER
14. Maiden Name Unknown
15 Birthplace

16 (a) Informant Mrs. Ollie K. Dickson
(b) Address Homewood Apartments

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. Md.

19 (a) DEC 9 1947 (Date rec'd by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to Nov 1947, and that I last saw him alive on Nov. 22 1947

Immediate cause of death: Arteriosclerosis Coronary Thrombosis — Duration: 7 Immed.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W. Dickson M. D.
Address 1109 St Paul St Date signed 12-5-47

657565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

657565 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 N. Stockton St.
(c) Hospital or institution: no 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 N. Stockton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Irving

3 (b) If veteran, name war: yes
3 (c) Social Security Account No. 218-05-6841

4. Sex: male 4-4.
5. Color or race:
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Elizabeth Irving
6 (c) If alive, give age 47 years
7. Birth date of deceased (mo.) Sept. 15 (day) 1900 (year)
8. AGE: Years 47 Months 3 Days 4 If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name John Irving
13. Birthplace Balto

MOTHER
14. Maiden Name Rose Jones
15. Birthplace Balto Md

16 (a) Informant Elizabeth Irving
(b) Address 710 N. Stockton St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/47 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Baltimore Md
18 (a) Funeral director Daniel R. Brown Son
(b) Address 1080 Montgomery Street
19 DEC 3 1947 (Date received by registrar) Huntington Williams M.D.

VS 150 .1 1818

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1947, at 12 10 M

21. I certify that death occurred on the date above stated; that I attended deceased Oct. 1 1947 to Nov 29 47 and that I last saw h alive on Nov. 29 47

Immediate cause of death: Influenza a Relapse — Duration 3 weeks
Due to: Bronchopneumonia developed — 7 days
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lipsohn Shelton M. D.
Address 708 S. Sharp St Date 12/2/47

657566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

657566 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 East North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER JORDAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Mary O'Gorman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1872

8. AGE: Years (75) | Months 9 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Boston, Mass.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Baltimore City

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Jean J. Dunn
(b) Address 226 W. Lafayette Ave.

17 (a) Burial (b) Date thereof 12/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~Cremation~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director John O. Waterbury & Sons
(b) Address 1900 Eutaw Place

19 (a) DEC 3 1947 (Date rec'd by registrar) (b) [illegible] Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/47 19 at 12:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions post-operative Umbilical Hernia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 12/3/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657567 AB-115356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓469

Registered No. 657567

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Frank Heath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2- 1867

8. AGE: Years 80 | Months 8 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation D.P.W.

11. Industry or business

FATHER
12. Name ? (D
13. Birthplace ? (D

MOTHER
14. Maiden Name ? (D
15. Birthplace ? (D

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Rd

18 (a) Funeral director D. Halsted
(b) Address 98 Druid Hill Ave.

DEC 3 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29- 1947 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19- 1947 to 11-29- 1947, and that I last saw h im alive on 11-29 1947.

Immediate cause of death Carcinomatosis of Peritoneal Cavity — Duration

Due to ? Primary site Pancreas

Due to

Other Conditions Obstruction of Bile [redacted]
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto. City Hosp. Date signed 12-1-47

X

568 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 557568

GM. 114880 CERTIFICATE OF DEATH 309

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 953 Madison AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archie Covington ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M & Sep.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 -1881

8. AGE: Years	Months	Days	If less than one day
66	6	-21	hr. min.

9. Birthplace VA.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Willis Covington
13. Birthplace VA.

MOTHER 14. Maiden Name Mollie ?
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 3 1947 (Date received by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30-47 1947, at 1.33A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30-1947 to 11-30-1947 and that I last saw him alive on Nov. 30 - 1947

Immediate cause of death Cerebral-vascular accident & left hemiplegia. — Duration a Long time

Due to Hypertension & Arteriosclerotic C.V.D disease. — years

Due to

Other Conditions Syphilis Malignant tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Farber M. D.
Address Balto City Hosps Date signed 12-1-47

937

657569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

657569 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 16 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.5 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora Holmes (Lora B. Holmes)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Fe | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Robert Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 72 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name unk
13. Birthplace N.C.

MOTHER 14. Maiden Name unk
15. Birthplace N.C.

16 (a) Informant Daisy McKoy
(b) Address 221 W. 129th St New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 DEC 3 1947 (Date rec'd by registrar) (b) Huntington for Williams Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1947, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1947 to 11/26 1947 and that I last saw h[illegible] alive on 11/26 1947.

Immediate cause of death	Duration
Hypertensive C-V Renal Disease	2.5 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M. D.
Address 1518 Division Date signed 12/5/47

657570

BALTIMORE CITY HEALTH DEPARTMENT

LH 92724

CERTIFICATE OF DEATH V13B

Registered No. 657570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Daisy Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5-1918

8. AGE: Years 28 | Months 4 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name London
13. Birthplace Va.

MOTHER
14. Maiden Name Nellie Thompson
15. Birthplace Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-1947 (month) (day) (year)
(c) Cemetery or crematory Westmoreland Co. Va.
Location

18 (a) Funeral director Mrs. Katie A. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 2 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1947, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 19 47 to Nov. 30 19 47, and that I last saw him alive on Nov. 30 19 47

	Duration
Immediate cause of death Pulmonary Tuberculosis, Ulcerated a Caseous	3 yrs.
Due to	
Due to	
Other Conditions Poss. Diseased	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W Parlow M. D.
Address Balt City Hosp. Date signed 12-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

657571

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 N. Carey St
(c) Hospital or institution: 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N. Carey St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Raley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William J. Raley.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): November 8 1879

8. AGE: Years: 68 | Months | Days: 21 | If less than one day: hr. min.

9. Birthplace: Mc Bee S.C. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Allen Johnson.
13. Birthplace: Mc Bee S.C.

MOTHER
14. Maiden Name: Dixie Bowman.
15. Birthplace: Mc Bee, S.C.

16 (a) Informant: William J. Raley
(b) Address: 702 N. Carey St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Dec 3, 1947 (month) (day) (year)

(c) Cemetery or crematory
Location: Mc Bee S.C.

18 (a) Funeral director: Mrs Katie B. Williams
(b) Address: 322 N. Schroeder St

19 (a) 1947 (Date rec'd by Registrar) (b) Huntingtown Williams Md. Registrar

DEC 3 1947

VS 150 .. 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29- 1947, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1947 to 11-29- 1947, and that I last saw her alive on 11/27 1947.

Immediate cause of death: Cardio Vascular Renal Disease, Apoplexy

Due to: Hypertension — Duration: 6 mos.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. L. Jackson M.D.

Address: 6001 Arlington Ave Date signed 12/3/47

(65)572 B.C.F. 2-93163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1161c

Registered No. 057572

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jeffrey Sell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 25, 1947

8. AGE: Years	Months	Days	If less than one day
5 wks	1	8	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name John Kosnel
13. Birthplace ?

MOTHER — 14. Maiden Name Dorothy Sell
15. Birthplace Carroll County, Md.

16 (a) Informant Harriet Sell
(b) Address Taneytown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-47 (month) (day) (year)
(c) Cemetery or crematory Reformed Cemetery
Location Taneytown, Md.

18 (a) Funeral director C. O. Fuss & Son
(b) Address Taneytown, Md.

19 (a) Dec 3 1947 (Date received by Registrar) (b) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1947, at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1947 to Dec 2 1947, and that I last saw him alive on Dec 2 1947.

	Duration
Immediate cause of death Dehydration & acidosis	2 days
Due to Operation Pulsion Diverticulum of undetermined Etiology	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard L Cohen M. D.
Address Sinai Hosp of Balto Date signed 12-3-47

VS 150

1578 Harry Lachman 2322 Callow Ave La 2887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 657573

8 3a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1723 Eason st.

(c) Hospital or institution: 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1723 Eason st.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John D. Grant

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 1st 1870

8. AGE: Years	Months	Days	If less than one day
77	2	0	hr. min.

9. Birthplace Fortress Monroe Va
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Machinist

FATHER 12. Name John W. Grant

13. Birthplace Unknown

MOTHER 14. Maiden Name Eliza J. Hobbs

15. Birthplace "

16 (a) Informant: Mary E. Stumph

(b) Address 1723 Eason st.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/5/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Oak Lawn

Location Eastern ave - Extended

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul st

19 DEC 3 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1st 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1947, to Dec 1, 1947 and that I last saw h~~e~~r alive on Dec 1 1947.

Immediate cause of death: Generalized Arteriosclerosis — Cerebral Hemorrhage — Duration: 10 yrs. 7 days

Due to:

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harry Lachman M. D.

Address 2322 Callow Ave Date signed Dec. 2, 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 57574

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 DIVISION ST
(c) Hospital or institution: PROVIDENT HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 PENNA AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country NONE

3 (a) **FULL NAME** JOHN GALLIMORE

3 (b) If veteran, name war NONE

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race NEGRO | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1868

8. AGE: Years 79 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Richmond, Virginia (Town, county, and state)

10. Usual Occupation Lobbyman

11. Industry or business

FATHER 12. Name

13. Birthplace Unknown

MOTHER 14. Maiden Name

15. Birthplace Unknown

16 (a) Informant Eddie Gallimore

(b) Address 524 Highland Ave Winston-Salem N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore Md

18 (a) Funeral director William A. Jackson

(b) Address 916 Pennsylvania Ave,

19 (a) DEC 3 - 1947 (Date rec'd by registrar) (b) Wilmington Delaware

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30/47 19 , at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12 1947 to 11/30 1947, and that I last saw him alive on 11/30 1947

Immediate cause of death LOBAR PNEUMONIA — Duration 20 days

Due to

Due to

Other Conditions HYPERTENSIVE CARDIOVASCULAR DISEASE

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William M. Barnes, M. D.

Address 1514 DIVISION ST Date signed 12/1/47

X

657575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

657575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 N. 25th Street
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. 25th Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Maud M. Sinclair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edgar Sinclair

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8-1883

8. AGE: Years: 64 | Months: 5 | Days: 24 | If less than one day: hr. min.

9. Birthplace A. A. Co., Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Elizabeth Disney

15. Birthplace Maryland

16 (a) Informant Donald M. Sinclair

(b) Address 410 N. 25th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4-1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Marys (Pamdon)

Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) DEC 2 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1947, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1947 to Dec 2 1947 and that I last saw h- alive on Dec 1 1947.

Immediate cause of death	Duration
Cardiac Insufficiency	5 yrs
Due to Hypertension	not known
Due to Senile degeneration	3 yrs
Other Conditions Renal Insufficiency	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roscoe H. Nolan M. D.

Address 438 Mary Land Date signed 12-2-47

65756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. 65756

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospital 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME HARRY (HOWARD) BREHM

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 24, 1894

8. AGE: Years	Months	Days	If less than one day
53	1	8	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name George Brehm
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lillian Johnson
15. Birthplace Harford County

16 (a) Informant Hella. Brehm
(b) Address 402 S. Mean St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/1947 (month) (day) (year)
(c) Cemetery or crematory U.S. National Cem.
Location Sudbrook Apt

18 (a) Funeral director Wendell Klopp
(b) Address 312 S. Hanover St

19 (a) DEC 3 1947 (Date rec'd by registrar) (Signature of Registrar) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1947, at 6.40 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

Signature Earl K. Rye, M.D.
Medical Examiner
Date signed 12-1-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 83B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ridgemede Apts.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country France

3 (a) FULL NAME Ferdinand Barra

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Catherine Barra
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 20, 1879

8. AGE: Years	Months	Days	If less than one day
68	9	20	— hr. — min.

9. Birthplace France (Town, county, and state)
10. Usual Occupation Estimator
11. Industry or business Real estate

FATHER
12. Name Henry Barra
13. Birthplace France

MOTHER
14. Maiden Name Jeanne Durand
15. Birthplace France

16 (a) Informant Catherine Barra
(b) Address Ridgemede Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert St.

19 (a) DEC 3- 1947 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1, 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1947, to Dec 1 1947, and that I last saw him alive on Dec 1 1947.

Immediate cause of death Cerebral embolism — Duration: 2 Days

Due to Angiosarcoma

Due to Arteriosclerosis and possible syphilis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy Not Granted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry T. Chase M. D.
Address Mercy Hospital Date signed 12/1/47

VS 150

Med Exam Case — 1753 Dda

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 B

Registered No. 65538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Released to Hospital
(a) Baltimore City, Maryland
(b) Street address 18 N
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Carrollton, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Forrest.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	married

6 (b) Name of husband or wife MARSHALL ?
6 (c) If alive, give age 527 years

7. Birth date of deceased (mo., day, yr.) 6-24-1897

8. AGE: Years	Months	Days	If less than one day
50	5	7	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name John Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Watts
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-47 (month) (day) (year)
(c) Cemetery or crematory BALTO. NATL.
Location BALTIMORE, Md

18 (a) Funeral director Charles Harper
(b) Address 510-12 N. Carrollton Ave

19 DEC 8 1947 Date received by Lurton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 — 1947 at 4 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Dead on arrival in accident room. Cause of death not determined. Pt had

Due to hypertensive C-V disease

c cardiac enlargement + mild failure

Due to She had had a thyroidectomy in 1942 + had post-op hypoparathyroidism

Other Conditions Fatal + Calc + C.C.

She was taking digitalis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Cardiac hypertrophy

Duration Hrs. Min. Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Grob M. D.
Address J H H Date signed 12 Dec 47

Sent to Hospital - by Howard J. Mercer, M.D. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057579 AB-114627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 057579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Nelson -or- Milbert Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10-1903

8. AGE: Years 44 | Months 9 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Nelson
13. Birthplace Maryland

MOTHER
14. Maiden Name Sophia Ward
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) Dec 3 1947 (Date received by Registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29- 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20- 19 47 to 11-29- 19 47, and that I last saw him alive on 11-29- 1947.

	Duration
Immediate cause of death Tuberculosis of Lungs Bilateral	
Due to Far Advanced	1yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Siegfried W. Parks M. D.
Address Balt City Hosp Date signed 12-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657580 ✓ 657580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 Ashland Ave
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Jones.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Clarence Jones.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 4 1899
8. AGE: Years 47 Months 4 Days 27 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Linker.
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Lee
15. Birthplace Md.

16 (a) Informant Clarence Jones
(b) Address 1313 Ashland Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4 1947 (month) (day) (year)
(c) Cemetery or crematory Lilburtus Memorial Park
Location
18 (a) Funeral director Robert L. Young
(b) Address 1216 N. Carline St.
19 (a) (Date received by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1947 at 6:15 P.M.
21. I certify that death occurred on the date above stated, that I attended deceased from 11/30 1947 to 12/1 1947 and that I last saw her alive on 12/1 1947

Immediate cause of death: Coronary occlusion — Duration: 1 day
Due to: hypertensive cardiovascular disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Rayner Browne M.D.
Address 1320 E. Madison St. Date signed 12/4/47

Rayner Browne X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. 657581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 mos
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Lorraine
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3392 E. Lorraine Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. McCarthy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. (S)

6 (b) Name of husband or wife Mary McCarthy

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 1-31-95

8. AGE: Years	Months	Days	If less than one day
52	11	2	hr. min.

9. Birthplace Penna
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Simon O. McCarthy
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen McHugh
15. Birthplace Ireland

16 (a) Informant Wife
(b) Address

17 (a) Burial (b) Date thereof 12/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location 1947

18 (a) Funeral director
(b) Address

19 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1947 at 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1947 to 12-2 1947 and that I last saw h alive on 12-2 1947

Immediate cause of death: Aspiration of Vomitus

Due to Decomposition

Due to Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Bronchi edema + Acute Pneumonia

of autopsy:

Duration
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A. Ort M. D.

Address Mercy Date signed 12-4-47

657382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

657382 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 N. Pulaski St.
(c) Hospital or institution: 20-21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Pulaski St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Rose Lindsay

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NO

4. Sex: FM
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John M. Lindsay
6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): April 1, 1888

8. AGE: Years 59 | Months 8 | Days 1 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: House Wife
11. Industry or business: Home

FATHER
12. Name: ? McDonald
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Maryland

16 (a) Informant: John M. Lindsay
(b) Address: 406 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/6/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore

18 (a) Funeral director: George W. Little
(b) Address: 2700 Edmondson Ave.

DEC 8 - 1947 (Date rec'd by registrar) (b) Huntington-Hilligoss-Mc... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 2, 1947 19 , at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27, 1947 to Dec. 2, 1947, and that I last saw her alive on Dec. 1, 1947

Immediate cause of death: coronary thrombosis — Duration: 1 day
previous attack Oct. 27, 1947
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Dwight D. Kemp M. D.
Address: 3030 Edmondson Avenue Date signed: 12/3/47.

X

657383

BALTIMORE CITY HEALTH DEPARTMENT ✓ 657383 Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2621 ~~Hafner~~ HAFER St.
(c) Hospital or institution: 204

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Hafner
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 ~~Hafner~~ HAFER St. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME James B. Whittaker

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	218-05-3588

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Blanche Whittaker
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1888

8. AGE: Years	Months	Days	If less than one day
59	2	18	hr. min.

9. Birthplace Essex County Va.
(Town, county, and state)
10. Usual Occupation Assembly Man
11. Industry or business Martin's

FATHER
12. Name James B. Whittaker
13. Birthplace Va.

MOTHER
14. Maiden Name Ida Lee
15. Birthplace Va.

16 (a) Informant Mrs. Blanche Whittaker
(b) Address 2621 Hafner St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/47 (month) (day) (year)
(c) Cemetery or crematory Farnham Church
Location Farnham, Virginia

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by Registrar) (Huntington Williams M.D. Registrar)

DEC 3 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1947 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1947 to Dec 1 1947, and that I last saw h~~im~~ alive on Dec 1 1947.

Immediate cause of death	Duration
Coronary Thrombosis	12 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward A. Kaelin M.D.
Address 1847 W. North Ave Date signed 12/3/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657584 — AB-U. 5551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

657584 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Bloomberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Sode -or- Maggie Sode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widow

6 (b) Name of husband or wife August (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8- 1864

8. AGE: Years	Months	Days	If less than one day
83 78	3	23	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Adam Walter
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sophie Hamill
15. Birthplace Baltimore, Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 4 47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Richie Highway

18 (a) Funeral director Wm. H. E. Broadis
(b) Address 7110 Belair Rd

19 DEC 3 1947 (Date received by Registrar) (b) Funkstown Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2- 19 47, at 10.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16- 19 35 to 12-1 19 47, and that I last saw h er alive on 12-1- 19 47

Immediate cause of death	Duration
a Intermediate Heart	yrs
Due to Coronary Occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: an abstract

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr M. D.
Address Belvedere Date signed 12/3/47

VS 150

X

657585 ✓ 657585

657585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town New Bedford
(If outside city or town limits, write RURAL and give town)
(d) Street No. 85 Armor St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Damon Morrill Stuart

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Virginia Wilbur Stuart
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr) April 29, 1908

8. AGE: Years	Months	Days	If less than one day
39	7	4	hr. min.

9. Birthplace Machisport, Maine
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Merchant Seaman

FATHER
12. Name Morril M. Stuart
13. Birthplace Machisport, Me.

MOTHER
14. Maiden Name Edwina Hanscomb
15 Birthplace Marshfield, Me.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4-47 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Balto Md.
18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave
19 (a) (Date filed by registrar) (b) Registrar

DEC 3- 1947
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1947, at 3:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1947 to Dec. 3 1947 and that I last saw him alive on Dec. 3 1947.

Immediate cause of death	Duration
Melano-sarcoma of axillary lymph nodes, lungs, liver and heart, meta-	2 yrs
Due to static; primary melanoma of skin of right flank	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/3/47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~D57586~~ BC & 95239

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30 F

Registered No. D57586

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution:
The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 May Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Powell (444550)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/1/47

8. AGE: Years	Months	Days	If less than one day
0	0	0	8 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Henry Powell
13. Birthplace Maryland

MOTHER
14. Maiden Name Esther White
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo DEC 1947

18 (a) Funeral director Commissioner of Health
(b) Address

1947 DEC 3 1947
(Date rec'd by registrar) Covington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1947, at 11:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947 to Dec. 1 1947, and that I last saw him alive on Dec. 1, 1947.

Immediate cause of death Asphyxia; ? mongolism; ? syphilis, Congenital — Duration

Due to Premature separation of Placenta

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature EC Williams M. D.
Address The Johns Hopkins Hospital Date signed 12-2-47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B.C 95170 BALTIMORE CITY HEALTH DEPARTMENT 157587 Registered No. 157587

CERTIFICATE OF DEATH 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 953 Bond St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-22-47

8. AGE: Years | Months | Days 5 4 | If less than one day ..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Dorothy Brown

15. Birthplace Record

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo DEC 3, 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 DEC 3 1947 (Date received by Registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1947 at 5 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1947 to Nov 26 1947 and that I last saw her alive on Nov 26 19 1947

Immediate cause of death Prematurity — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Theill Lipsanlet M. D.

Address Johns Hopkins Hospital Date signed Nov 29 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17588 (65)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 657588 1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Yorkhaven (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wanda Myrel Wagner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-22-47

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace: Pa (town, county, and state)

10. Usual Occupation: Child

11. Industry or business

FATHER — 12. Name: Clarence Wagner
13. Birthplace: Pa

MOTHER — 14. Maiden Name: Arlene Gross
15. Birthplace: Pa

16 (a) Informant: Records.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical Schoo DEC 1947

18 (a) Funeral director: Commissioner of Health
(b) Address

19 (a) DEC 2 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947, at 3 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1947 to Nov. 27 1947, and that I last saw h alive on Nov. 27 1947

Immediate cause of death	Duration
Bilateral Pneumonia	
Due to: Tracheo-esophageal fistula.	
Due to: Esophageal atresia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-25-47

Major findings of operation: Esophageal atresia, 2: Tracheal Esoph. Fistula

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. H. Spahn M. D.

Address Johns Hopkins Hospital Date signed 11/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7589 B.C 4-952 BALTIMORE CITY HEALTH DEPARTMENT ✓ 160a 7589 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution: The Johns Hopkins Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Hartford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Butler (375330)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-1-47

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Lewis Moore
13. Birthplace Maryland

MOTHER
14. Maiden Name Marguerite Butler
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo DEC 3, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 3 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1947, at 12:10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1947, to Dec. 2, 1947, and that I last saw him alive on Dec. 2, 1947.

Immediate cause of death ? Intracranial injury ? Aspiration and asphyxia — Duration

Due to Breech presentation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B C Williams M. D.
Address The Johns Hopkins Hospital Date signed 12-2-47

X

657.90 ✓ 657.90

657.90 BC-B-94826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 754
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town ~~Baltimore~~ Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 7th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHNS HOPKINS HOSPITAL Donald Horwath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-47

8. AGE: Years	Months	Days	If less than one day
14 days		14	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrew Horwath
13. Birthplace Pa

MOTHER 14. Maiden Name Dorothy Smith
15. Birthplace England

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A.Co.

18 (a) Funeral director Charles F. Dell
(b) Address 1501 E. Fort Ave.

19 (Date rec'd by registrar) DEC 3 1947 (Huntington for Nathanson, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1947 at 9:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1947 to Dec 2 1947 and that I last saw him alive on Dec 2 1947

Immediate cause of death Cardiac Failure

Duration

Due to Congenital anomaly of the heart — Correction done.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Barton Childs

Address Johns Hopkins Hosp Signed 3 Dec 47 M.D.

VS 150

657591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 657591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Henry Fowler

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife: Susanna Fowler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19 1869

8. AGE:	Years	Months	Days	If less than one day
78	78	10	24 15	hr. min.

9. Birthplace Carroll Co
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Noah Fowler
13. Birthplace Carroll Co

MOTHER
14. Maiden Name Ann Orr
15. Birthplace Ireland

16 (a) Informant Susanna Fowler
(b) Address Owings Mills

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6-47 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Carroll Co

18 (a) Funeral director J. F. Klein & Sons
(b) Address Reisterstown Md.

19 (a) DEC 3 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1947, at 12 40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Andersen M.D.
Medical Examiner.
Date signed 12-3-47

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Birth Certificate 95178 (557392)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 557392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Turners Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 New Pittsburg Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME "Baby" Johnson (287669)

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) 10/31/47

8. AGE: Years	Months	Days	If less than one day
0	0	0	0 hr. 45 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Albert Johnson
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ruby Waddy
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) DEC 4 1947 (Date filed by Registrar) (b) Covington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1947, at 1:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 1947, to Oct. 31 1947, and that I last saw him alive on Oct. 31 1947.

Immediate cause of death	Duration
Prematurity (600 grams.)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B C Williams M. D.

Address The Johns Hopkins Hospital Date signed 11-20-47

657593 BC-C98244 JL - 115467

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159 ✓ Registered No. 657593

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. (-1)
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N. Exeter St- 3
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Baby Boy Spencer- Edith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nathaniel Spencer
13. Birthplace Md.

MOTHER
14. Maiden Name Edith Kent
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Disposition Cremated 9am (b) Date thereof 11-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 DEC 4 - 1947 (Date rec'd by Registrar) (b) Thurston Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26, 1947 at 2.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1947, to Nov. 26 1947, and that I last saw h. im alive on Nov. 26 1947.

Immediate cause of death	Duration
Congenital Atelectasis	1 day
Due to Prematurity	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Prematurity, Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Malcolm L. Griffin M. D.
Address Balt City Hosp Date signed 2 Dec 47

657594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

657594 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Elmhurst Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Sudbrook Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Howard Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie L. Graves

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	widow

6 (b) Name of husband or wife Roswell W. Graves
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1861

8. AGE: Years	Months	Days	If less than one day
85	11	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. E. Wyatt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sophia Hollingsworth
15. Birthplace Sykesville, Carroll Co. Md.

16 (a) Informant Sophie A. Graves
(b) Address Sudbrook Park Pikesville Md

17 (a) Burial (b) Date thereof Dec 4 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Garrison Forest Md

18 (a) Funeral director Henry N. Jenkins Sons Co
(b) Address McCulloh & Orchard, Balto

19 (a) Dec 4 1947 (b) Huntington Mills Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1947, at 6 02 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1947, to Dec. 2 1947, and that I last saw h. alive on Dec. 2 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Adv atherosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Isaacs M. D.
Address 1700 Eutaw Pl. Date signed 12-3-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. 657595

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 Chapel Gate Lane
(c) Hospital or institution: Ventnor Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4y 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Urath Cromwell Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widow

6 (b) Name of husband or wife Chas. B. Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 1859

8. AGE: Years	Months	Days	If less than one day
88	4	9	hr. min.

9. Birthplace Garrison Pikesville Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles T Cockey
13. Birthplace Balto Co Md

MOTHER
14. Maiden Name Susannah Brown
15. Birthplace Frederick Md

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Dec 4 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Garrison Forest Md

18 (a) Funeral director Henry McJenkins & Bro Co
(b) Address McCulloh & Orchard Sts

19 (a) DEC 4 - 1947 Huntington Williams Md
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1947, at 1 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Nov 1947 to Dec 2 1947 and that I last saw her alive on Dec 2 1947.

Immediate cause of death	Duration
Auricular fibrillation	3 weeks
Due to Arteriosclerotic Cardio-vascular disease with	years
Due to myocardial degeneration	
Other Conditions Marked senility.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emil H. Henning Jr M. D.
Address 4580 Edmondson Ave. Date signed Dec 2 1947
Balto 29 Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

557596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 553598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Ln
(c) Hospital or institution: Home For The Aged Door 2-1-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Midwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Adam Schmidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1875

8. AGE: Years	Months	Days	If less than one day
71	11	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Gebhardt

13. Birthplace

MOTHER 14. Maiden Name Sauer

15. Birthplace

16 (a) Informant Lee Linton (Son) Dec 2 1947

(b) Address 1209 Valley Ln.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director A. Reiley Slade

(b) Address 4907 York Rd.

19 (a) DEC 4 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1947, at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947, to Dec 2 1947, and that I last saw her alive on Dec 2 1947.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions Arterio-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 E North Av Date signed Dec 3-47

VS 150

X

057597 KROWLING

BALTIMORE CITY HEALTH DEPARTMENT

LW 29379

CERTIFICATE OF DEATH

Registered No. 057597

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Rosedale
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (Welfare) 7935 - 33rd St. Rosedale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Erwin Krowding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12- 1871

8. AGE: Years 76 | Months 10 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace W. Virginia MARTINSBURG
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Krowding
13. Birthplace Pa.

MOTHER
14. Maiden Name Fannie Howe
15. Birthplace Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A. Co. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 127 St. Paul St

19 (a) DEC 4 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1- 19 47 4:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19- 1946 to Dec. 1 1947, and that I last saw h im alive on Dec. 1- 1947

Immediate cause of death Carcinomma of Esophagus with metastases & Tracheoesophageal Fistula — Duration

Due to

Due to

Other Conditions Senile Emphysema Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation 12/1/47

Major findings of operation: metastases to subdiaphragmatic glands

of autopsy: ad advisa

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank L. Parsons M.D.

Address Baltimore City Hospitals signed 12/3/47

X

BC

657598 3-9432 BALTIMORE CITY HEALTH DEPARTMENT 657598
CERTIFICATE OF DEATH 64 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 Durst Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LINDA LEE TOWNSEND

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Nov 10th 1947

8. AGE: Years | Months | Days 28 | If less than one day ____hr. ____min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Townsend
13. Birthplace Farmville Va.

MOTHER 14. Maiden Name Tressie Helmick
15. Birthplace Elkton W. Va.

16 (a) Informant Joseph Townsend
(b) Address 1233 Durst St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/5/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) DEC 4 1947 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1947, at 7.20 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Status thymicolymphaticus
Acute pulmonary edema.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12/5/47

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

657599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

657599 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 269 S. McCurley st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 269 S. McCurley st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelm H. Reinke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife Maria Reinke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7th 1860

8. AGE: Years 87 | Months 7 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Farming

FATHER
12. Name William Reinke
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace "

16 (a) Informant Charles Reinke
(b) Address 5008 Hazel Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/5/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 [illegible] Baltimore, Md.

19 DEC 4 - 1947 (b)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3rd 1947, at 4a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 31 19 47 to Dec 3 19 47 and that I last saw him alive on Dec 3 19 47

Immediate cause of death: Cardiac Failure — Duration: 5 days
Due to: Arteriosclerosis — 2
Due to: Senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Lohn M.D.
Address 1025 Fulton Date signed 12/3/47

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

657600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

657600 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2415 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2415 Baker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry G. Atwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Nellie Atwood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16th 1873

8. AGE: Years 74 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Vermont (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Alfred Atwood
13. Birthplace Unknown

MOTHER
14. Maiden Name Elzira "
15. Birthplace "

16 (a) Informant Anna Tennien
(b) Address 708 W. Lexington St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/5/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Pine Hill
Location Brandon, Vermont

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) DEC 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1947, at 9 PM

21. I certify that I took charge of the remains described above, held an Insp. + Aut. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rogers M.D. (Medical Examiner)
Date signed 12-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

357601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. 357601

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 264 S.Highland Ave.
(c) Hospital or institution: 26

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 264 S.Highland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wm. Benjamin Evans

3 (b) If veteran, name war --
3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary M.Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.15,1869

8. AGE: Years	Months	Days	If less than one day
78	1	16	hr. min.

9. Birthplace Chase Md. (Town, county, and state)
10. Usual Occupation Sexton
11. Industry or business

FATHER
12. Name Nicholas Evans
13. Birthplace Md.

MOTHER
14. Maiden Name Martha ----
15. Birthplace Md.

16 (a) Informant Mrs. Mary M. Evans
(b) Address 264 S.Highland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Co. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) (Date filed by Registrar) (b) Huntington Williams M.D.

DEC 6 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1947, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 1947, to 12/1 1947, and that I last saw him alive on 12/1 1947.

Immediate cause of death Asphyxia
Pulmonary Edema
Due to Acute Dilatation of the Heart
Due to Concussion of the Cerebrum

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 12hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh J. Scott
Address 337 E. Balto St. Date signed 12/7/47

657602 Gielner BALTIMORE CITY HEALTH DEPARTMENT 657602

CERTIFICATE OF DEATH 937

Registered No.

Every item of information should be carefully supplied. The... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 S Luzon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 S Luzon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Andrew Henry Gielner Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-14-2676

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Victoria
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877
8. AGE: Years 70 | Months | Days | If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Gielner
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Victoria Gielner
(b) Address 715 S Luzon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6 1947 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave.

DEC 4 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1947, to Dec 3 1947, and that I last saw h. alive on Dec 2 1947

Immediate cause of death	Duration
Arteriosclerotic & C-V Disease	
Hypostatic Pneumonia	
Due to Cerebral Hemorrhage	Nov 26/47
Bronchopneumonia	Nov 29/47
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Head

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl Schumacher M. D.
Address 842 S Ed Ave Date signed 12-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. 657603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 691 W. Mulberry
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 691 W. Mulberry
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma J. Biddle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Nicholas Biddle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28 - 1868

8. AGE: Years 79 | Months 5 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm Thomas
13. Birthplace Md

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Md

16 (a) Informant Jeneta Biddle
(b) Address 691 W. Mulberry St

17 (a) B (Burial, cremation, or removal) (b) Date thereof 12-5-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Samuel H. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

19 (a) DEC 4 1947 (Filed by registrar) (b) Custer for Williams M.D. Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1947, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1947, to Dec 2 1947, and that I last saw h alive on Dec 2 1947.

Immediate cause of death
Acute Myocarditis — 1 day
Cerebral apoplexy — 1 day
Due to Hypertension — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. A. Berry M. D.
Address 1430 E. Chase Date signed 12-3-47

057604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186

Registered No. 057604

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 CAROLINE ST
(c) Hospital or institution: ST JOSEPH'S HOSP 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 62
(e) Length of stay in Baltimore (yrs., moe., or days) 66

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Roland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MATILDA NECKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Frederick B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25 - 1860

8. AGE: Years 87 Months 2 Days 9 If less than one day hr. min.

9. Birthplace [illegible] Md. GERMANY (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name Hoehl

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Fr. Frederick J. Nuckey

(b) Address St. James Church

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto.

18 (a) Funeral director L. J. Ruck

(b) Address 5345 Harford Road.

19 (a) DEC 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1947 at 1355 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1947 to Dec 3 1947 and that I last saw h[illegible] alive on Dec 3 1947

Immediate cause of death CARDIO-RESP failure

Due to HYPERTENSIVE C.V.D.

Due to ARTERIO-SCLEROSIS

Due to FRACTURED FEMUR

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/14

(a) Accident, suicide, or homicide

(b) Date of occurrence Nov 5 at ? A M

(c) Where did injury occur? Balto Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? SISTERS VILLA While at work? NO (Specify type of place)

(e) Means of injury Fall on floor

23. Signature John B Weeks

Address St Jos Hosp Date signed 12-3-47 M. D.

VS 150 To be approved by Med Examiner Emil Beyer M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Bowles

657605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1358 Registered No. 657605

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 St Paul St -
(c) Hospital or institution: athome 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 St Paul St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florine Elmon Bowles

3 (b) If veteran, name war: No | 3 (c) Social Security Account No. No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: F. D. Bowles

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 6 1872

8. AGE: Years 75 | Months 8 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Louisanna (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Wm. A. Elmon
13. Birthplace Louisanna

MOTHER
14. Maiden Name Myra A Minor
15. Birthplace Louisanna

16 (a) Informant Mrs Florine B. Brewer (daughter)
(b) Address 1619 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore

18 (a) Funeral director Stewart Hammond Co
(b) Address 101 W Monument Ave

19 (a) DEC 4 - 1947 (Date rec'd by registrar) (b) Interring for Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1947 at 11:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29 1947, to 12-3 1947, and that I last saw her alive on 11-30 1947

Immediate cause of death: Uremia — Duration 7 days

Due to Urinary Bladder Retention — 10 days

Due to

Other Conditions: old age; Decubitus Sores; Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Harree Pierce M.D.
M.D.
Address 312 Med. Arts Bldg Date signed 12-3-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 052605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. BROADWAY
(c) Hospital or institution: Church Home and Hospital 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) ~~County~~ Baltimore City.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 W. OAKDALE Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Galloway Woodall

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Casper R. Woodall
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec-12-1868

8. AGE: Years	Months	Days	If less than one day
78	11	20	hr. min.

9. Birthplace Baltimore MARYland.
(Town, county, and state)
10. Usual Occupation MANAGER BOARDING House
11. Industry or business Room + BOARD House

FATHER
12. Name Agnella GALLOWAY
13. Birthplace Balto. MARYLAND

MOTHER
14. Maiden Name MARY E. Kelley
15. Birthplace MARYLAND.

16 (a) Informant MRS MARGARET FAUNTLEROY
(b) Address 102 W. Oakdale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5 '47 (month) (day) (year)
(c) Cemetery or crematory Sherwood
Location Cockeysville, Maryland

18 (a) Funeral director Stewart & Mowing Company
(b) Address 128 W. North Ave, City

19 (a) DEC 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1947 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1947 to Dec 2 1947 and that I last saw her alive on Dec 2 1947.

Immediate cause of death	Duration
ANTERIOR Myocardial Infarction	4 days
Due to ARTERIOSclerotic coronary thrombosis	4 days
Due to ARTERIOSclerotic coronary Heart Disease	15 YRS
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ANT. Myocardial infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lee M. Daward M. D.
Address Church Home Hospital Date signed 12/4/47

X

657607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 657607

PRINT NAME, USING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ? - 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 S. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Earl Harner (EARL EUGENE HARNER)

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. 216-14-4496

4. Sex MALE

5. Color or race White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife LOLA HARNER

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 16 - 1891

8. AGE: Years 55 | Months 11 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace Kingsdale - PENNA.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Painter - etc.

FATHER
12. Name LEVI HARNER
13. Birthplace Kingsdale, Adams Co., Pa.

MOTHER
14. Maiden Name LAURA STERNER
15. Birthplace Littlestown, Pa.

16 (a) Informant Mal G.G. Strandberg
(b) Address % Salvation Army - 926 S. Fremont Ave. City

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11 - 4 - 47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. - Md.

18 (a) Funeral director Stewart & Mahon Company
(b) Address 108 W. North Ave. - City - 1

19 (a) Dec 4 - 1947 **(b)** Received by (Signature) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1947, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1947, to Dec 2 1947 and that I last saw h. alive on Dec 2 1947.

Immediate cause of death	Duration
Cardiac failure -	
Cardiac Decompensation	
Due to Hypertension C.V. Disease	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Edward Burkhart
Address 711 Bird Ave. Date signed 12/3/47

VS 150

931

WATSON

657608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

657608 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 45 E Hughes
(c) Hospital or institution: 22

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 45 E Hughes
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Amanda Watson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lin Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/1908

8. AGE: Years 39 | Months - | Days 7 | If less than one day hr. min.

9. Birthplace Seaford Del
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Lin Watson
(b) Address 45 E Hughes St

17 (a) Buried (b) Date thereof 12/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cy
Location Balto Md

18 (a) Funeral director Isaac L Brown & Son
(b) Address 108 W Monument St

19. DEC 4 - 1947 Registered by Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1946 to 12-2 1947 and that I last saw h alive on 12-2 1947

Immediate cause of death Hypertension Chronic Vascular Disease — Duration 1 Yr 3 Mo

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 537 Dolphin Date signed 12-4-47

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 057609

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ mos
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Gough St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Viola Lukowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Thomas Lukowski
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 27, 1891

8. AGE: Years	Months	Days	If less than one day
56(?)	1	6	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Housf.
11. Industry or business

FATHER
12. Name John Bronzert
13. Birthplace Poland

MOTHER
14. Maiden Name Stella Ukrucha
15. Birthplace Poland

16 (a) Informant Thomas Lukowski
(b) Address 2206 Gough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co.

18 (a) Funeral director Wm. L. Flaherty
(b) Address 2007 Eastern ave

19 (a) Received by (Registrar) 1947 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1947 at 12 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral vascular accident	
Due to Hypertensive cardiovascular	
Due to disease	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert E May
Address 1400 N. Caroline St Date signed M, D 12/2/47

VS 190

937

357610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45c ✓

Registered No. 357610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 240 S. Eaton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(c) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 240 S. Eaton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gunther

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Katherine P. Gunther
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) May 28th, 1863

8. AGE: Years 84 | Months 5 6 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Albert Gunther
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Elizabeth Gunther
(b) Address 240 S. Eaton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery
Location O'Donnell Street

18 (a) Funeral director Frederick D. Miller, Inc.
(b) Address 3019 E. Monument Street

19 DEC 4 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2nd 19 47 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1946 to 12-2 1947 and that I last saw h[illegible] alive on 12-2 1947

Immediate cause of death	Duration
CARCINOMA MOUTH + NECK	1½ Yrs.
Due to	
Due to	
Other Conditions ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James F. Kavanagh M.D.
Address 2014 McElderry St. Date signed 12-1-47

VS 3

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information supplied.

Balto. City Health Dept

~~MARYLAND STATE DEPARTMENT OF HEALTH~~
~~2411 N. Charles St., Baltimore~~

057611

CERTIFICATE OF DEATH 13a

Reg. Dist. No.

057611

1. PLACE OF DEATH:

County

City or town Baltimore City
(If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital, or institution: Cold Spring Nursing Home

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Spals-Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Glenrose Rd
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Mary Louise Price

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband or wife Evan Emory Price

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1885

8. AGE:

Years	Months	Days	If less than one day
62	9	14	hrs. min.

9. Birthplace Sparks, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Wm. Norton Carlisle
13. Birthplace Balto. Co., Md

MOTHER
14. Maiden name Anne Rebecca Rayden
15. Birthplace Balto. Co., Md

16. Informant Thomas Price
Address Monkton Md

17. Burial Date thereof Dec. 6, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Jerusalem
Location Sparks, Maryland

18. Funeral director Landon M. Brooks
Address Sparks Md.

19. Filed Dec 6 1947 Thurlington Williams, M.D.
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3-47 19 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1- 38 to 12-3-47 19

and that I last saw h alive on 12-2-47 19

Immediate cause of death	DURATION
Uremic Coma	3 days
Due to nephritis	3 yrs
Due to hypertension	years
Arteriosclerosis	years
Other conditions Cerebral hemorrhage	3 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L. Saffell M. D. or other

Address Registered nurse Md. Date signed 12/4/47

X

57612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 057612

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1633 N. Washington Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 N. Washington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMALIA SCHAD

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Frederick Schad
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 16, 1873

8. AGE: Years	Months	Days	If less than one day
74	0	16	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name William F. Holdefer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Holdefer
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Anna M. Courtney
(b) Address 1633 N. Washington Street

17 (a) Burial (b) Date thereof 12-5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

DEC 4 - 1947
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1947, at 7 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947 to Dec 2 1947 and that I last saw h-r alive on Dec 1 1947.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Coronary sclerosis	10 yrs.
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry J. Conley M.D.
Address 165 E. E. Balto. Date signed Dec 2 '47

VS 150

057613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No. 057613

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Carey

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife Augusta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/1891

8. AGE: Years	Months	Days	If less than one day
56	9	17	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Cyrus Carey
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Augusta Carey
(b) Address 1706 Laurens St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director George H. Kelson
(b) Address 323 Pulaski Highway

19 DEC 4 - 1947 (Date rec'd by registrar) Huntington for Nathaniel Wolf Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1947, at M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Blast injury of face
Due to
Other Conditions Carcinoma of Rt Kidney
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 15/2
(a) Date of injury 12-1-47 at 1 p. M.
(b) Where did injury occur? 1706 Laurens St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Wood Stove explosion-

23. Signature Earl L Kyle M.D.
Medical Examiner
Date signed 12-2-47

VS 151

57614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 138

Registered No. 57614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1541 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1541 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edgar Powell

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-4047

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Sep.

6 (b) Name of husband or wife Helen Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27 - 1903

8. AGE: Years	Months	Days	If less than one day
44	2	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name James W. Powell
13. Birthplace Md

MOTHER
14. Maiden Name Mary Jackson
15. Birthplace Md

16 (a) Informant Helen Powell
(b) Address 1113 Harlem ave

17 (a) Burial (b) Date thereof 12 5 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 417 E. Preston St

19 (a) DEC 4 - 1947 (b) Huntington Williams, M.D.
(Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1947, at 7 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1947, to Dec 2 1947, and that I last saw him alive on Nov 30 1947.

Immediate cause of death	Duration
Acute Congestive Heart Failure	App 3 wks
Due to	
Due to	
Other Conditions Pulmonary Tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Holland Chiswell Jr M. D.
Address 902 W. Franklin Date signed 12-2-47

VS 150

93E

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§ 3a

057615 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Elmley Ave
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Elmley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Teresa Elizabeth Danaher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Jeremiah J. Danaher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9 1874

8. AGE: Years 73 | Months 11 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland not
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Wolf
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Ott
15. Birthplace Germany

16 (a) Informant E. L. Grady
(b) Address 3716 Yorkmite Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Fredrick Rd

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Baltimore

19 (a) DEC 4 - 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1st 1947, at 5.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from — 1943 to 12-1 1947, and that I last saw her alive on Dec 1 1947.

	Duration
Immediate cause of death: Central Hemorrhage	1 da.
Due to: Arteria sclerosis	4-5 yr.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Dan Moran M. D.
Address 3105 Belair Rd Date signed 12-2-47

VS 199

65761 ✓ 65761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 Falsom St.
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Falsom St. (If rural give location)
FALSOM
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna J. Maddox ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John Maddox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14. 1859

8. AGE: Years	Months	Days	If less than one day
88	3	20	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name P. Riley
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Lottie M. Fletcher
(b) Address 417 Falsom St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Glouster Virginia.

18 (a) Funeral director Flynn + Fleming
(b) Address 1426 Light St.

19 (a) [illegible] (Date rec'd by registrar) (Signature of Registrar) Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 - 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1947 to Dec 3 1947 and that I last saw h[illegible] alive on Dec 3 1947.

Immediate cause of death
- Bronchial Pneumonia

Duration 7 days.

Due to
Influenza

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. J. Mellet M. D.
Address 1279 Mulberry St Date signed 12/4/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

657617 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Riverside
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Allen (Edgar Allen)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December-11-1894

8. AGE: Years	Months	Days	If less than one day
52	11	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Allen
13. Birthplace Maryland

MOTHER
14. Maiden Name Francis Murray
15. Birthplace Maryland

16 (a) Informant Mrs Hilda Zimmerman
(b) Address 1217 Riverside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. G. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1420 Light St

19 (a) DEC 4 - 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Dec 1947, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Dec 1947 to 2 Dec 1947 and that I last saw h-m alive on 2 Dec 1947.

Immediate cause of death	Duration
1a. Cardiac decompensation	
2. Chronic alcoholism	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Laham M.D.
Address Franklin Sq. Hosp Date signed 3 Dec '47

057618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

057618 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Baltimore
(a) Baltimore City, Maryland
(b) Street address 730 N. Bruce st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 N. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Elizabeth Lyles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Married

6 (b) Name of husband or wife Lawrence Lyles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years	Months	Days	If less than one day
33 yrs	-	-	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Steve Ward.
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Watkins
15. Birthplace Va.

16 (a) Informant Annie Ward Nulf.
(b) Address 730 N. Bruce st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location West Ront Balto md

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 927 N. Mount St.

19 (a) Hunting Williams, M.D. (Date rec'd by registrar) Registrar

DEC 4 - 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1947, at 9:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 2 1947 and that I last saw her alive on Dec 1 1947

Immediate cause of death Coronary Occlusion — Duration Appx. 12 hrs.
Due to
Due to
Other Conditions Diabetes Mellitus Infection of foot (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D Garland Chiswell Jr M. D.
Address 902 W. Franklin Date signed 12-1-47

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 927

Registered No. 67619

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2322 Essex St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2322 Essex St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanislawa (Stella) Sobczynski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Walenty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Pokorska
15. Birthplace Poland

16 (a) Informant Anthony J. Sobczynski
(b) Address 2322 Essex St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

DEC 4 - 1947 (Date rec'd by registrar) (b) Registrar's signature Clifton Hollinsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2- 1947 at 1:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1947 to Dec 2nd 1947 and that I last saw h-- alive on November 30 1947.

Immediate cause of death	Duration
Valvular Heart disease	3
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverstein M. D.
Address 22 S. Broadway Date signed Dec. 3 - 1947

V S 150

657620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. 657620

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 346 S. Drew St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HERMAN C. HERDA (HERDA)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26-1871

8. AGE: Years 76 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation SECT. L.O.U.F.

11. Industry or business

FATHER 12. Name Unk

13. Birthplace

MOTHER 14. Maiden Name Unk

15. Birthplace

16 (a) Informant Mrs Albert F. Herda

(b) Address 1520 Round Hill Rd

17 (a) Burial (b) Date thereof Dec. 6 47 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pikesville

Location Taylor Ave

18 (a) Funeral director Hoffberger & Co

(b) Address 411 Eastern Ave

19 (a) DEC 4- 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1947, at 3 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Edema, Bronchio-pneumonia

Due to

Other Conditions Decubitus ulcers, back. Fx. Rt tibia, Left Pelvis + Wrist, Pelvis (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following: 26/5

(a) Date of injury 11-3-47 at 2 a. M.

(b) Where did injury occur? Cornwall & Eastern Ave. Baltimore, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian-struck by auto

23. Signature Earl L. Kruger M.D. Medical Examiner.

Date signed 12-3-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. The... write the causes of death clearly and legibly.

157621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 157621

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County.....
(c) City or town Marshall (If outside city or town limits, write RURAL and give town)
(d) Street No. Victor Drive Box 66 (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Patricia Moore

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Child
6 (b) Name of husband or wife —
6 (c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 6/1946
8. AGE: Years 1 | Months 6 | Days | If less than one day ... hr. ... min.
9. Birthplace Texas (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Earl Moore
13. Birthplace Texas

MOTHER
14. Maiden Name Katherine Stephens
15. Birthplace Texas

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 4th (month) (day) (year)
(c) Cemetery or crematory Algoma Cemetery
Location Marshall Texas

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2005 Orleans St

19 (a) DEC 4 1947 rec'd by Registrar (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1947 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1947 to Dec. 4 1947, and that I last saw her alive on Dec. 4 1947

Immediate cause of death: Pulmonary Congestion with blood — Duration
Due to: Congenital heart defect
Due to: Transposition of the great vessels of the heart
Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:.....
of autopsy: — as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ... M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?.....
(e) Means of injury —

23. Signature John S. Moore M. D.
Address John Hopkins Hosp. Baltimore Md. Date signed 4 Dec 47

57622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1122a

Registered No. 57622

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 4-8
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 78

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 Harford Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Cadwallader

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Louis Cadwallader

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-69

8. AGE: Years 78 | Months - | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Dietrich
13. Birthplace Balto

MOTHER
14. Maiden Name Dont Know
15. Birthplace Dont Know

16 (a) Informant Mrs Henry Kaiss
(b) Address 2218 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5th (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ellicott Funeral Home
(b) Address 2105 Orleans.

19 (a) DEC 4 1947 (b) [illegible] Registrar
(Date rec'd by deg...)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Dec 1947, at 9:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Nov 1947 to 2 Dec 1947 and that I last saw her alive on 2 Dec 1947.

Immediate cause of death Cardio Resp Failure — Duration

Due to Hypertensive cardio vascular disease

Due to

Other Conditions Fractured femoral neck, right
(Include pregnancy within 3 months of death)

Date of operation 11-28-47

Major findings of operation: Gangrene of bone

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Kilgannon M.D.
Address St Josephs Hosp. Date signed 12/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

1557623 Registered No.

GM. 115375

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Franklin ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife Lydia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
(Ret) 66			hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 S. Schroeder St.

DEC 4 - 1947 (Date rec'd by registrar) (b) Huntington for Matthews, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 - 1947, 10 45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 - 1947, to Nov. 30 - 1947, and that I last saw him alive on Nov. 30 - 1947.

Immediate cause of death Arteriosclerotic Heart Disease with Cardiac Hypertrophy & Dilatation — Duration: weeks.
Due to Generalized Arterio-sclerosis — yrs.
Due to Arteriosclerosis of lower Extremities and Superficial Gangrene of Right Foot. — yrs. weeks.
Other Conditions Frost bite Both feet. Cut. Edema — days
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rush C. Netterville M. D.
Address Balt. City Hosp. Date signed 12-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Medical & Case

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH / 1579

Registered No. 1575524

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 W. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Mijanovich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-20-47

8. AGE: Years | Months | Days | If less than one day
0 47 Days 14 hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Paul Mijanovich
13. Birthplace Md

MOTHER 14. Maiden Name Thelma Angle
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-5-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Lawn
Location Williamsport Md

18 (a) Funeral director C. M. Sutin & Sons
(b) Address Hagerstown Md

19 (c) DEC 4 1947 (b) Thurlington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Dec 1947, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1947 to 12/3 1947 and that I last saw h[illegible] alive on 3 Dec 1947.

Immediate cause of death	Duration
Asphyxia - Other anesthesia	
Due to Rocket-Ist Adopted Edema	
Due to 1. Esophageal Atresia	
2. Tracheo-esophageal fistula.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 3 Dec 47.
Major findings of operation: - as above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 3 Dec. 1947 at M
(c) Where did injury occur? Johns Hopkins Hosp.
(City or town) (County or street address)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No
(Specify type of place)
(e) Means of injury Died on operating table (Nature of injury)
23. Signature P. H. Strahan M.D.
Address Johns Hopkins Hosp. Date signed 3 Dec 47 M.D.

Homer J. Meserve, M.D.

X

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-57625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83A

B-57625

Registered No.

The entry of every item of information should be carefully supplied. Use ink. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd.
(c) Hospital or institution: Colonial Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Lynbrook N.Y.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 Marion St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony J. Moelter-MOELTER

3 (b) If veteran, name war

3 (c) Social Security Account No. 072-09-7179

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife late Ethel Moelter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1883

8. AGE: Years	Months	Days	If less than one day
64	4	12 10	hr. min.

9. Birthplace New York N.Y.
(Town, county, and state)
10. Usual Occupation Expeditor
11. Industry or business

FATHER
12. Name Joseph T. Moelter
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Sicknberger
15. Birthplace Germany

16 (a) Informant Robert T. Moelter (Son)
(b) Address Great Bend Penna.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6/47 (month) (day) (year)
(c) Cemetery or crematory Maple Grove
Location Kew Gardens N.Y.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 DEC 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Dec 1947 at 1:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Nov 1947 to 4 Dec 1947 and that I last saw him alive on 30 Nov 1947

Immediate cause of death	Duration
Cerebral Hemorrhage, spontaneous	12 hrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl L. Royer M. D.
Address 142 Wantagh Pkwy Date signed 4 Dec 47

VS 150

57626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

S-57626

Registered No. 1248 657626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3[illegible]
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 Mewington ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie M. Zafren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Morris Zafren

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1893

8. AGE: Years 53 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Hyman Judelwitz
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael Leah
15. Birthplace Russia

16 (a) Informant Morris Zafren
(b) Address 803 Mewington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5 47 (month) (day) (year)
(c) Cemetery or crematory Brai Israel Cemetery
Location Southern ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1734-36 W. North ave

19 DEC 5 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 19 47 at 8 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 4 1947 and that I last saw h[illegible] alive on Dec 4 1947

Immediate cause of death	Duration
Cardiac decompensation	
Due to	
Due to	
Other Conditions Xanthomatosis biliary cirrhosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 12/7/47

95c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-57627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B-57627 Registered No. 657627

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2200 LINDEN AVE
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 LINDEN AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** SAMUEL GOODMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Noami
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept, 24, 1868

8. AGE: Years	Months	Days	If less than one day
79	2	10	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Israel Goodman
13. Birthplace Russia

MOTHER
14. Maiden Name Eva ?
15. Birthplace Russia

16 (a) Informant William Goodman
(b) Address 2200 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Mishkin Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) DEC 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 4 1947, at 8.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 to 12/4 1947, and that I last saw he alive on 12/3 1947.

Immediate cause of death	Duration
Bronchio-pneumonia	1 week.
Due to Multiple Cerebral Hemorrhage	
Due to Hypertension & Cardiac Hypertrophy	8 years.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sundan Cooper M. D.
Address 2201 Eutaw Place Date signed 12/7/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

7628 V 93 D

Registered No. 25[illegible]28

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Fremont ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Richard Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-1878

8. AGE: Years	Months	Days	If less than one day
69	11	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Platter
13. Birthplace Providence, R. I.

MOTHER
14. Maiden Name Hannah Kemp
15. Birthplace Md.

16 (a) Informant Ernest Bailey
(b) Address 1133 Fremont Ave

17 (a) Burial (b) Date thereof Dec. 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 [illegible] 5- 194[illegible] (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1947 at 10 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1947 to 12-2 1947 and that I last saw her alive on 12-2 1947

Immediate cause of death	Duration
Congestive heart failure	
Due to Hypertensive, arteriosclerotic	
Due to heart disease	
Other Conditions Hypostatic pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address St. Joseph's Hosp. Date signed 12/[illegible]/47

17329 / Copy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94A

Registered No. 17329

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1490 Cherry St
(c) Hospital or institution: 25-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1490 Cherry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anastazie Jarvba

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Jakanlen Jarvba

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1883

8. AGE: Years 64 | Months | Days 22 | If less than one day hr. min.

9. Birthplace Hrmmitz (Town, county, and state) Bohemia

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Becvar
13. Birthplace Bohemia

MOTHER
14. Maiden Name Conny Rehorova
15. Birthplace Bohemia

16 (a) Informant Frank Jarvba
(b) Address 1490 Cherry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Balto Md

18 (a) Funeral director Frank Evachitas
(b) Address 980 W Chester St

19 DEC 5 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1947, at 6:15 M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Raf Sulbrooke M.D.
Medical Examiner.
Date signed 12/2/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. 057330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2715
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 W Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maddox, Carrie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb-10-1899

8. AGE: Years 48 | Months 9 | Days 27 | If less than one day hr min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Major Starks
13. Birthplace S C

MOTHER
14. Maiden Name [illegible] Kelsey Eliz.
15. Birthplace S C

16 (a) Informant Caroline Tracey
(b) Address 1206 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5 1947 (month) (day) (year)

(c) Cemetery or crematory St Joseph's
Location Fenno, Balto Co

18 (a) Funeral director C. Benjamin Dorsey
(b) Address 2615-17 E Baltimore St

19 Dec 5 1947 (b) [illegible] Huntington Williams, M.D.
(Date received) (Registrar)

VS 15b 1-48

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Dec 1947 at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Nov 1947 to 2 Dec 1947 and that I last saw h[illegible] alive on 2 Dec 1947.

Immediate cause of death	Duration
Pulmonary embolism	
Due to Auric Fibrillation	
Due to Mitral Stenosis Rheumatic Heart Dis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy Mitral Stenosis. Pulmonary Embolism

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. J. Lahm M. D.
Address Franklin Sq Hosp. Date signed 2 Dec 47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83A

Registered No. 057331

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 W 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Peeples.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widower.

6 (b) Name of husband or wife: Florence E. Peeples

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26, 1874

8. AGE: Years 72 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Peeples.
13. Birthplace N. C.

MOTHER
14. Maiden Name Judith Kendall
15. Birthplace N. C.

16 (a) Informant Alfred O'Neil Peeples
(b) Address 4017 Beelwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5/47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampstead

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) DEC 5 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1947, at 5 30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 21 1947 to Dec 3 1947 and that I last saw h[illegible] alive on Dec 3 1947

Immediate cause of death: Pasalepes — Duration 3 hr

Due to

Due to

Other Conditions: Cerebral Haemorrhage — Duration unk

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Dec 4/47 (Date signed)
Address 112 W. 25th St.

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 057632

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 N. Bradford St.
(c) Hospital or institution: qr

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 N. Bradford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry C. McKeldin

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-5911

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Emma E. McKeldin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15th 1885

8. AGE: Years	Months	Days	If less than one day
62	4	17	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Own

FATHER
12. Name Wm McKeldin
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Scott
15. Birthplace Balto. Md.

16 (a) Informant Hattie Blades
(b) Address 1513 N. Bradford St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/5/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 5 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2nd 1947 at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Dec 2 1947 and that I last saw h.. alive on Dec 2 1947

Immediate cause of death	Duration
Coronary Occlusion	1 min
Due to Lines Degeneration	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Williams M.D.
Address 1217 St. Paul St. Date signed 12-4-47 M.D.

657633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94A

Registered No. 657633

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT CLEARLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 2-W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4314 Walther Blvd (14)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Louis J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14th 1889

8. AGE: Years	Months	Days	If less than one day
58	4	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Louis J. Schneider
(b) Address 4314 Walther Blvd

17 (a) Burial (b) Date thereof 12/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3 1947 at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29 1947 to 12-3 1947, and that I last saw her alive on 12-3 1947

Immediate cause of death Coronary occlusion — Duration

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C B Hearns M. D.
Address Univ. Hosp. Date signed 12-3-47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

7634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 657634

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 E. Lanvale St.
(c) Hospital or institution: 125
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SALLIE LYNN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband Christopher C. Lynn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25th 1876

8. AGE: Years	Months	Days	If less than one day
71	3	8	hr. min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name James A. Rankin
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary T. Brumlow
15. Birthplace Tenn.

16 (a) Informant Miss Dovie Lynn
(b) Address 200 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 5- 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1947, at 10 a.m.

21. I certify that I took charge of the remains described above, held an insp. & inq. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wellers M.D. Medical Examiner.
Date signed 12-3-47

65635 BALTIMORE CITY HEALTH DEPARTMENT ✓ 65635
CERTIFICATE OF DEATH 93D Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 N. Fremont Ave.
(c) Hospital or institution: 143
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriett Stewart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1867

8. AGE: Years 80 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace West River, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James E. Blake
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Smith
15. Birthplace Md.

16 (a) Informant Mrs. Martha Budd
(b) Address 1303 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Maryland.

18 (a) Funeral director Mrs. Frances A. Heisley
(b) Address 878 W. Biddle St.

19 DEC 5- 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Dec. 2, 1947, at 6:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20/1947 to 12/2/1947, and that I last saw h[illegible] alive on 12/2/1947.

Immediate cause of death: Uremic Myocarditis — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Hawkins, M.D.
Address 45 W. Biddle St. Date signed 12-4-47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~37636~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH B1A

Registered No. 1537636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1518 Druid Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F, 5. Color or race N, 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 Months Days If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace

MOTHER 14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Mrs. Thompson
(b) Address 1608 Division St.

17 (a) Burial (b) Date thereof 12-6-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Thos. Truman & Bennett
(b) Address 1578 W. Biddle St.

DEC 5 1947 (Date rec'd by registrar) (b) Lavington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 1947 at 3:22 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1947 to 12/3 1947 and that I last saw h.e alive on 12/2 1947

Immediate cause of death Hypertension C-V Renal Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Paxton Grant M.D.
Address 1514 Division Date signed 12-4-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7637

BALTIMORE CITY HEALTH DEPARTMENT ✓ 657637
CERTIFICATE OF DEATH 94A
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2823 INDIANNA AVE
(c) Hospital or institution: 25

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 INDIANNA AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES. T. PRINCE.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-0969

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife KATHERINE PRINCE
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) JAN 27-1902

8. AGE: Years	Months	Days	If less than one day
45	10	6	....hr. ....min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation CABINET MAKER
11. Industry or business

FATHER
12. Name CHARLES PRINCE
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name LOUISA-A BLOCKENGER
15. Birthplace PA.

16 (a) Informant KATHERINE PRINCE
(b) Address 2823 INDIANNA. AVE

17 (a) BURIAL (b) Date thereof DEC 6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lohnerty. Cem
Location O DONNALL ST- Balt

18 (a) Funeral director Bernard C Hartle
(b) Address 121 E West St

19 (DEC 5- 1947
(Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 3 1947, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Mar 1947 to 3 DEC 1947 and that I last saw h[illegible] alive on 3 DEC 1947

Immediate cause of death CORONARY OCCLUSION — Duration 1 YEAR
Due to ARTERIOSCLEROSIS
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward F Miles MD
Address 682 Wyoming Ave Cumberland signed 10-4

VS 150

X Baltimore 30 Md

65738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186A

65738 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 Mallow Hill Ave.
(c) Hospital or institution: 28.4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Mallow Hill Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret (Maggie) Schiller

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Frederick G. Schiller
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) September 3- 1871

8. AGE: Years	Months	Days	If less than one day
76	3	—	hr. min.

9. Birthplace Germany (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Daniel Getz
(b) Address 215 Mallow Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Rhoderick Ave.

DEC 5 - 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1941, to December 3 1947, and that I last saw h.. alive on December 2 1947

	Duration
Immediate cause of death: Acute pulmonary Congestion	2 da.
Due to: Compound Comminuted Fracture Lt. radius	5 da.
Due to: Arteriosclerosis Senility	27 yr.
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 28.4
(b) Date of occurrence November 23, '47 at 5 P.M.
(c) Where did injury occur? Home: Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home: While at work? No
(Specify type of place)
(e) Means of injury: Fell from bed

23. Signature Nelson K. Gallagher M.D.
Address Catonsville 28, Md. Date signed 12/4/47

Howard J. Hopkins, M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 62A

Registered No. S-57639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1-3
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 868 Park avenue (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Groscup

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widowed

6 (b) Name of husband or wife deceased.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28/1880

8. AGE: Years	Months	Days	If less than one day
66	11	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Zimmerman
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Gilligan
15. Birthplace Ireland

16 (a) Informant William H. Groscup
(b) Address 4040 Hollen Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Meyers and Son
(b) Address 805 N. Calvert St.

19 (a) DEC 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/47 19 , at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 19 47 to 12/3 19 47 and that I last saw h[illegible] alive on 12/3 19 47.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebro-vascular	
Due to accident.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Scott M.D.
Address Mercy Hospital Date signed 12/3/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

657640 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 11-B
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 N. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME A. Gordon Hayes
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 21, 1867
8. AGE: Years 80 Months 9 Days 13 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John S. Hayes
13. Birthplace Virginia

MOTHER
14. Maiden Name Susan Cosby
15. Birthplace Balto, Md

16 (a) Informant Miss Susan Hayes
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6 1947 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry McKenrick's Sons
(b) Address McCulloh & Orchard Sts

19 DEC 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4-47 19 at 11:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 1947 to 12-4 1947, and that I last saw him alive on 12-4 1947.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature James McC. Finney M. D.
Address Union Memorial Hosp. Date signed 12-4-47

657041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4E

657041 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution: Univ. Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Apt E², West Univ. Pkwy; #18 4404 Fair (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roger W Clapp

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. R. W. Clapp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1910

8. AGE: Years	Months	Days	If less than one day
37	1	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Reg. Veterans Administration
11. Industry or business V.A.

FATHER
12. Name H. Rowland Clapp
13. Birthplace Rhode Island

MOTHER
14. Maiden Name Eliz. Ficke Johnson
15. Birthplace New York

16 (a) Informant Hosp. Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7 1942 (month) (day) (year)
(c) Cemetery or crematory Mt Nottingham
Location Colora Md

18 (a) Funeral director Henry W Jenkins & Son
(b) Address McCulloh & Richards Sts

19 DEC 5 - 1942 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/42 19 , at 1:33 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30/42 19 to 12/4/42 19 , and that I last saw him alive on 12/4/42 19 .

Immediate cause of death Gen. carcinomatosis	Duration
Due to Hepatic metastasis	
Due to Carcinoma of colon	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/30/42
Major findings of operation: Carcinoma of colon & generalized carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. Luke Richardson
Address Univ. Memorial Hosp. Date signed 12/4/42 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48A

Registered No. 15672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 N. Linden Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH MULLENAX

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 - 1912

8. AGE: Years 35 | Months 8 | Days 29 28 | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Secretary

11. Industry or business State Government

FATHER
12. Name John Hurley
13. Birthplace Md.

MOTHER
14. Maiden Name Susan Sommers
15. Birthplace Md.

16 (a) Informant John M Taylor
(b) Address 147 Duke of Gloucester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8-47 (month) (day) (year)
(c) Cemetery or crematory St Anns Cem
Location Annapolis Md.

18 (a) Funeral director E. W. Tamburean
(b) Address 1093 W. Baltimore St.

19 DEC 5 - 1947 (Date rec'd by registrar) (b) Washington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1947, at 11 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from today 19 to 19, and that I last saw h alive on Dec 4 1947.

Immediate cause of death: Respiratory failure from pulmonary edema — Duration 3 hr.
Due to Uremia — 1 wk.
Due to Ca of cervix c metastases — 1 yr.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 2
Major findings of operation: Ca of cervix c metast.
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G Buckner M. D.
Address Mercy Hosp Date signed 12/4/47

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 0528643

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5250 Reisterstown Road
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5250 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alvieda Grove

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Benjamin F. Grove
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 10, 1859

8. AGE: Years	Months	Days	If less than one day
88	9	23	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Jacob Fleischer
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Elisabeth Robinson
15. Birthplace Scotland

16 (a) Informant Mr. Herbert R. Groves
(b) Address Riveria Beach, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Miller Lamoreau
(b) Address 4610 Liberty Heights Ave.

19 (a) DEC 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 19 47, at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased ~~from~~ ~~to~~ the last 14 years and that I last saw her alive on 12-2 1947.

Immediate cause of death Diabetes — Duration Several years

Due to Cardiac asthenia — Duration 6 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Russell
Address 5302 Groveland Ave. Date signed 12/8/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1557644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. 1557644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 733 Newington Ave.
(c) Hospital or institution: 32
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 733 Newington Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROY KAUFMAN.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-2051.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1889.

8. AGE: Years	Months	Days	If less than one day
58	2	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Collector
11. Industry or business

FATHER
12. Name David Kaufman,
13. Birthplace Germany.

MOTHER
14. Maiden Name Cecelia Cousins,
15. Birthplace Balto. Md.

16 (a) Informant Mr. Wm. Kaufman,
(b) Address Riviera Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.5.47. (month) (day) (year)
(c) Cemetery or ~~crematory~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director David Lanzkron & Son
(b) Address 1902 Eutaw Place

19 (a) DEC 5- 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3rd. 1947, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1947 to Dec 5 1947, and that I last saw h~~e~~r alive on Nov 20 1947.

Immediate cause of death	Duration
Coronary thrombosis	1 day
Due to Coronary artery disease	1 year
Due to see other side	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Frederick Leib M. D.
Address Temple Garden Apts. Date signed 12/4/47

over

G57645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 949

G57645
Registered No.

Please write the information called for clearly and correctly. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 134
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2826 - Woodbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES Arthur HADDAWAY

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-09-3780

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Genevieve M. Haddaway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 11-1884

8. AGE: Years	Months	Days	If less than one day
63	10	23	hr. min.

9. Birthplace Chapel, Md. (Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Baltimore Transit Co.,

FATHER
12. Name Hugh Haddaway
13. Birthplace Tilghmans, Md.

MOTHER
14. Maiden Name Sallie Kirby
15. Birthplace Maryland

16 (a) Informant Mrs. Genevieve M. Haddaway
(b) Address 2826 Woodbrook Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/47 (month) (day) (year)
(c) Cemetery or crematory Tilghman
Location Talbot County, Maryland.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

DEC 5 - 1947 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1947, at 5 20/60 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis.
Hypertrophy, dilatation, and
~~Duration~~ scarring of heart.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/4/47

Please write the causes of death clearly and legibly. The information must be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

657648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 108

657648
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 Brewer St.
(c) Hospital or institution: 172
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1122- Brewer St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT MASON ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lula
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 7/1/'80

8. AGE: Years	Months	Days	If less than one day
67	5	3	hr. min.

9. Birthplace W. Moreland County, Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William
13. Birthplace Virginia

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Eunice Mason
(b) Address 1122 Brewer Street

17 (a) Burial (b) Date thereof 12/8/'47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McCulloh St.

19 (a) DEC 5 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1947, at 1.35 a.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH lobar pneumonia

Due to

Other Conditions Arteria-sclerotic cardio-vascular disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royle M.D.
Medical Examiner
Date signed 12-4-47

G57647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

Registered No. G57647

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The [illegible] of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 N. Calhoun St.
(c) Hospital or institution: Franklin Square 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Hollins Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Schwartz

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14th 1876

8. AGE: Years 71 | Months | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name John M. Schwartz
13. Birthplace Europe

MOTHER
14. Maiden Name Elizabeth (Unknown)
15. Birthplace Europe

16 (a) Informant Miss Catherine Schwartz
(b) Address 1006 Hollins St.

17 (a) Burial (b) Date thereof 12/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem.
Location O'Donnell St.

18 (a) Funeral director John E Boyce & Sons
(b) Address 1101-3 Hollins St.

19 (a) DEC 5 - 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/47 19..... at 7:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy/Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Rheumatoid Arthritis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Dark M.D.
Medical Examiner.
Date signed 12/3/47

X

657648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

657648 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 Sargeant St.
(c) Hospital or institution: 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Sargeant St - (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maude L. Mendel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Geo Mendel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown 1872

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name Geo F. Scherneck
13. Birthplace Germany

MOTHER
14. Maiden Name Wakenroth
15. Birthplace Germany

16 (a) Informant Mrs Carroll

(b) Address 1306 Sargeant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/47 (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Edgewood & Ash Aves

18 (a) Funeral director John J Cowan & Son

(b) Address 2003 Gallows St -

19 DEC 5 - 1947 (Date rec'd by Registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/1947 at 2:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1947, to Dec 3 1947 and that I last saw h alive on Dec 3 1947.

Immediate cause of death: Myocarditis — Duration 2 1/2 yrs

Due to: Hypertension — Duration 5 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jean Yates

Address 517 Acott St Date signed 12/4/47 M. D.

65 7649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

1557649 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2122 Penrose Ave
(c) Hospital or institution: 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 Penrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dennis Akern

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Delia C. Akern
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26th 1881

8. AGE: Years	Months	Days	If less than one day
66	9	7	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Boiler Maker
11. Industry or business American Co.

FATHER
12. Name Unknown
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mrs. Delia Condon
(b) Address 2122 Penrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John F. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) DEC 5 - 1947 (Date received by registrar) (b) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3rd 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1947, to Dec 3 1947 and that I last saw him alive on Dec. 3 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions Coronary Thrombosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elmer Langlein M. D.
Address 410 N. Payson St. Date signed 12/4/47

V S 150

X

657650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

657650
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3633 Elm Avenue
(c) Hospital or institution: 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3633 Elm Avenue (If Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Mary E. Krout

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. ~~Sex~~ Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles E Krout
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 31-1877

8. AGE: Years 70 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Bart Edrington
13. Birthplace Maryland

MOTHER
14. Maiden Name Mollie Booker
15. Birthplace Maryland

16 (a) Informant Charles E. Krout
(b) Address 3633 Elm Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6-1947 (month), (day), (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) DEC 5 1947 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3- 1947, at 8:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947 to Dec 3 1947, and that I last saw her alive on Dec 3 1947.

Immediate cause of death. Terminal Bronchio-pneumonia — Duration 2 days

Due to Chronic Cardio-Renal disease + arteriosclerosis — Duration 8 yrs.

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Noam Dudrow

Address 846 W 36th St - Date signed 12/4/47

65/2651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 65/2651

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2078 Druid Park Drive
(c) Hospital or institution: 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2078 Druid Park Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary A. Forsythe

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William J. Forsythe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1- 1860

8. AGE: Years	Months	Days	If less than one day
87	3	1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name James A. Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Williams
15. Birthplace Maryland

16 (a) Informant Mrs. Lewis F. Batchelor
(b) Address 2078 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5-1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 DEC 5- 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2- 1947, at 9.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1947, to 12/2 1947, and that I last saw her alive on 11/25 1947.

Immediate cause of death	Duration
Cardiovascular accident	
Due to Hypertension Cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Doenhurst M. D.
Address 14 E. Eager St Date signed 12/3/47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B3B

Registered No. 57652

57652

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3521 Falls Rd (11)
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph E. Barnes

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Widowed

6 (b) Name of husband or wife Goldie Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 - 1895

8. AGE: Years	Months	Days	If less than one day
52	4	28	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business

FATHER
12. Name William A. Barnes
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Robinson
15. Birthplace Md.

16 (a) Informant Mrs. George Cooper
(b) Address 3976 Elm Avenue

17 (a) Burial (b) Date thereof Dec 6-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Maryland

18 (a) Funeral director Burgle Funeral Home
(b) Address 3631 Falls Road

19 (a) DEC 5 1947 (b) Huntington Williams M.D.
(Date rec'd by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3 1947 at 10:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1947 to 12-3 1947 and that I last saw h(er) alive on 12-3 1947

Immediate cause of death	Duration
Uremia	
Due to Congenital Polycystic Kidneys	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C B Heaver M. D.
Address Manor Hosp. Date signed 12-4-47

VS 150

X

057653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 057653

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Cynnns Falls Pkwy
(c) Hospital or institution: 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Cynnns Falls Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MILDRED S. BRESSLER

3 (b) If veteran, name war —

3 (c) ~~Social Security~~ Account No.

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife ALBERT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 44 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace BALTO. MD (Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business

FATHER 12. Name WOLFE HONDEN

13. Birthplace LATVIA

MOTHER 14. Maiden Name IDA HONDEN

15. Birthplace LATVIA

16 (a) Informant ALBERT BRESSLER

(b) Address 1605 CYNNS FALLS PKWY

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-7-47 (month) (day) (year)

(c) Cemetery or crematory HEBREW FRIENDSHIP

Location BALTO. + CONKLIN ST

18 (a) Funeral director JACK LEWIS INC

(b) Address 2100 EUTAW PLACE

19 DEC 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 1947, at 4 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1947, to Dec 4 1947, and that I last saw her alive on Dec 4, 1947

Immediate cause of death	Duration
Generalized Carcinomatosis	5 mos
Due to Carcinoma of left ovary	8 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation June 20, 1947

Major findings of operation: Mucinous Carcinoma of left ovary

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel P. Manneker M. D.

Address 1910 N. Mark Ave Date signed Dec 5, 1947

052654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

052654 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3103 Oakley Ave 27-17
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 Oakley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Morris -
13. Birthplace Russia

MOTHER
14. Maiden Name Lena -
15. Birthplace Russia

16 (a) Informant Samuel Cohen
(b) Address 3103 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12- (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Hunter's Lane

18 (a) Funeral director Jack Kline Inc
(b) Address 2100-02 Eutaw Place

19 (a) DEC 5- 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5-47 19 45, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1947 to 12-4 1947 and that I last saw h alive on 12/4 1947.

Immediate cause of death: Acute Bronchitis
Duration:
Due to: Ch Diabetes
Due to:
Other Conditions: Sclerosis of vessels of leg.
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —
23. Signature A. L. Hornstein M. D.
Address 2048 Eutaw St Date signed 12/5/47

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B 57655 Reg. 115572 — Registered No. 13B — Registered No. 1-5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 South Chester St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - -

3 (a) FULL NAME: Harry L. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Sept.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 18/ 1886

8. AGE: Years 61 | Months 8 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation CARPENTER

11. Industry or business -

FATHER
12. Name Robert Smith (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida Mae Crispt
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-8-1947 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location O'DONNELL ST.

18 (a) Funeral director LILLY & ZEILER INC
(b) Address 403 S. WOLFE ST. (31)

19 (a) DEC 5 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION — P M

20. DATE OF DEATH Dec. 3/ 1947 19 ..., at 8.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 19 47 to Dec 3rd 19 47 and that I last saw h 2m alive on Dec 3rd 19 47

Immediate cause of death: Pulmonary tuberculosis, bilateral, far advanced with — Duration: years
Due to cavitation
Due to
Other Conditions Arteriolar nephrosclerosis, hemorrhoids
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 12-4-47

VS 150

PRESS WELL FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

657656 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-14
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. more
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Harvest Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Brooks, Clarence A.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	374-09-9530

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of ~~husband~~ wife Mary Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1893

8. AGE: Years	Months	Days	If less than one day
54	5	3	hr. min.

9. Birthplace Vermont St. Albans (Town, county, and state)
10. Usual Occupation Lab. Manager
11. Industry or business Smithers Stevens

FATHER
12. Name Edward H. Brooks
13. Birthplace St. Albans, Vermont

MOTHER
14. Maiden Name Mary Paul King
15. Birthplace Danville, Pa.

16 (a) Informant Mrs. J.C. Evans (Landlady)
(b) Address 3 Harvest Rd.

17 (a) Removal (b) Date thereof 12/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Greenwood
Location St. Albans, Vermont

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17 Md.

19 DEC 5 - 1947 (b) Huntington Nelligan M.D. Registrar
(Date rec'd by registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1947, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1947, to Dec. 4 1947, and that I last saw him alive on 4 Dec 1947

Immediate cause of death	Duration
Myocardial infarction	
Due to Coronary occlusion	
Due to Arteriosclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq Hosp Date signed 4 Dec 1947

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57657 JL - 115581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. 57657

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 26-1
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Tallagsen or James Tallaksen

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-1394

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 6 1898

8. AGE: Years 49 | Months 8 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Engineer.

11. Industry or business Standard Oil Co.

FATHER
12. Name Carl Tallaksen
13. Birthplace Norway

MOTHER
14. Maiden Name Annie Schmidt
15. Birthplace Germany.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-47. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director Charles S. Zeiler
(b) Address 904 S. Conkling St.

19 DEC 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 19 47, at 3.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 19 47 to Dec. 3 19 47 and that I last saw h... alive on Dec. 3 1947.

	Duration
Immediate cause of death: Pulmonary Edema	days
Due to: Arteriosclerotic Heart disease & cardiac insufficiency	?
Due to: Chronic Alcoholism	years
Other Conditions: Cirrhosis & hepatic insufficiency ? ascites (Include pregnancy within 3 months of death)	years

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 12-4-47

X

57658 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 57658

CERTIFICATE OF DEATH 131A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3723 Fait Ave.
(c) Hospital or institution: 16-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3723 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUST DROMMELHAUSER

3 (b) If veteran, name war -----

3 (c) Social Security Account No. 212-05-8409

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine Drommelhauser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1900

8. AGE: Years 47 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Conductor.

11. Industry or business Baugh Chemical Co.

FATHER
12. Name August Drommelhauser
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Caroline Rau
15. Birthplace Balto., Md.

16 (a) Informant Catherine Drommelhauser
(b) Address 3723 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd.

18 (a) Funeral director Charles S. Geiler.
(b) Address 901 S. Conkling St.

19 DEC 5 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1947, at 3 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947 to Dec 3 1947.
That I last saw him alive on Dec 3 1947.

Immediate cause of death Acute Cardiac Failure

Due to Cardio-Vascular Renal Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Flanigan M.D.
Address 3503 Fait Ave. Date signed 12-4-47

V S 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. 57659

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Broadway
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life (74 yrs)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 99 Admiral Blvd. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) **FULL NAME** EDWARD B. Flashell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Cora L. Horney

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1874

8. AGE: Years 72 | Months 11 | Days 3 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William Flashell
13. Birthplace Baltimore

MOTHER
14. Maiden Name MARY Freeman
15. Birthplace Baltimore

16 (a) Informant Edward B. Flashell
(b) Address (the deceased)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory, Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 DEC 5 - 1947 (Date Rec'd by Registrar) Huntington Woods, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1947, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947, to Dec. 3 1947, and that I last saw HIM alive on Dec. 3 1947.

	Duration
Immediate cause of death: Cardiac insufficiency AND	12 days
Due to: pulmonary edema	2 years
Due to: Arteriosclerotic Heart Disease	
Other Conditions: Mesenteric Thrombosis & Lower Ileum (terminal) (Include pregnancy within 3 months of death)	

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos M. Howard M. D.
Address Church Home & Hosp. Date signed 12/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057660
AB-114805

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. 057660

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 1mo.?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Dillehunt or James Dillehunt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 1881

8. AGE: Years	Months	Days	If less than one day
66?			hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. James Buchannon (D
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5. 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore City
Location

18 (a) Funeral director Mrs. John W. Deufel & Son
(b) Address 5-1947 Edmondson Ave

19 (a) DEC 5- 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3- 1947 at 5.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1947, to 12-2 1947, and that I last saw him alive on 12-2- 1947.

Immediate cause of death Uremia — Duration weeks

Due to Arteriosclerosis Pneumonia left lower lobe cause? — years

Due to Arteriosclerotic heart Disease Enlarged heart — week

Other Conditions Nephritis, decubitus ulcers, anemia — ? wks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosps. Date signed 12-4-47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

657661 — 117A — Registered No. 657661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 North Caroline St
(c) Hospital or institution: St. Joseph's Hospital 10-1
(d) Length of stay in hospital or inst. (~~yrs., months, days~~) 1 day
(e) Length of stay in Baltimore (yrs., ~~months, days~~) 50 (Entire)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Forrest St. #2 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Edward King
3 (b) If veteran, name war
3 (c) Social Security Account No: 218-10-3103

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband~~ or wife: Ellen E. King
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 18 Oct 1897

8. AGE: Years 50 | Months 1 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Plasterer
11. Industry or business

FATHER
12. Name James Jos. King
13. Birthplace Ireland

MOTHER
14. Maiden Name Alice Keenan
15. Birthplace Ireland

16 (a) Informant Mrs. Nellie King
(b) Address 1006 Forrest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) [illegible] (Signature, city, registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Dec 1947 at 11:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Dec 1947 to 2 Dec 1947 and that I last saw h/his alive on 2 Dec 1947

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Shock	
Due to Peritonitis	
Other Conditions Ruptured Peptic Ulcer H.T.M.	

(Include pregnancy within 3 months of death.)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Knife

23. Signature J. Joseph Kaylor M. D.
Address 1400 N. Caroline St. Date signed 12-2-47

Howard J. Wessin, M.D.

VS 130

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 657662

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Harford Ave.
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Harford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Deal

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (d) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rosemond M. Deal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1873

8. AGE: Years	Months	Days	If less than one day
74	0	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John F. Deal
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary H. Roycroft
15. Birthplace Maryland.

16 (a) Informant Walter W. Deal
(b) Address 6402 16th St. N.W. , Wash. D.C.

17 (a) Burial (b) Date thereof 12/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 DEC 5 1947 Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1947, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6-47 19 to Dec 4 1947 and that I last saw h[illegible] alive on Dec 4 1947.

Immediate cause of death Coronary insufficiency — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack J. Singer M.D.
Address 51 E. Mount Ave Date signed Dec 5 1947

VS 150

657663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

657663 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3011 Weaver Ave.
(c) Hospital or institution: 27-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 Weaver Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert H. Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Minnie McCleary Robinson
6 (c) If alive, [illegible] years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1883

8. AGE: Years	Months	Days	If less than one day
65	10	26	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Engneer
11. Industry or business Dept. of Edu. City of Balto.

FATHER
12. Name Aquilla Bond
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sarah F. Glover
15. Birthplace Baltimore

16 (a) Informant Mrs. Minnie Bond
(b) Address 3011 Weaver Ave.

17 (a) Burial (b) Date thereof 12/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) (b) Williams, M.D.
(Signature and title of local registrar) Registrar

DEC 8 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1947 at 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Dec 3 1947 and that I last saw him alive on Dec 3 1947.

Immediate cause of death Cerebral Hemorrhage — Diabetes Mellitus — Duration 1 day / 1 month

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E. Karlson

Address 4331 Harford Rd Date signed 12/3/47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 57664

57664 13A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 5 (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Christopher F. Dieterly

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-07-2133

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Edna C. Dieterly
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 4-7-1887

8. AGE: Years	Months	Days	If less than one day
60	7	28	hr. min.

9. Birthplace Balto - Md (Town, county, and state)
10. Usual Occupation Repair Man
11. Industry or business Jewelry

FATHER
12. Name Christopher Dieterly
13. Birthplace Md

MOTHER
14. Maiden Name Anna —
15. Birthplace Md

16 (a) Informant Wife
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Balto Md

18 (a) Funeral director Philip Henry Sant
(b) Address 2074 Eutaw Pl

19 (a) DEC 5 - 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 1947 2:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 1947 to 12-4 1947 and that I last saw him alive on 12-4 1947

Immediate cause of death	Duration
Intra Ventricular Cerebral Hemorrhage	2 hr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Sant M. D.
Address Mercy Date signed 12-4-47

VS 150 To be Approved By Chief Medical Examiner Thomas L. Anderson, M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

057665 | Registered No. 057665

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1042 Somerset St.
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1042 Somerset St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary E. Butt

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: John A. Butt
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) June 6, 1882
8. AGE: Years 65 | Months 5 | Days 29 | If less than one day ____ hr. ____ min.
9. Birthplace Minnesota (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Patrick O'Hara
13. Birthplace Minnesota

MOTHER
14. Maiden Name Katherine Glasco
15. Birthplace Minnesota

16 (a) Informant John A. Butt
(b) Address 1042 Somerset St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director The Dippel Brothers
(b) Address Lombard & Ann Sts.
19 DEC 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1947, at 4 M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1945 to 12/4 1947. and that I last saw her alive on 12/4 1947.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arteriosclerotic C.V.D. Disease	?
Due to	
Other Conditions Diabetes Mellitus	1-2-4

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Joseph L. Klein M.D.
Address 106 E. Preston St. Date signed 12/4/47

V S 150

947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

557656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 94A

Registered No. 557656

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16, 9, 28
(e) Length of stay in Baltimore (yrs., mos., or days) 16, 9, 28

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County FREDERICK
(c) City or town Emmitsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. Western Maryland
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Olivia Cassidy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-12-1869

8. AGE: Years	Months	Days	If less than one day
78	4	23	hr. min.

9. Birthplace Germantown, Pennsylvania
(Town, county, and state)
10. Usual Occupation Religious Sister
11. Industry or business Daughter of Charity of St. V. de P.

FATHER
12. Name James Cassidy
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Haggarty
15. Birthplace Ireland

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Road, Balto 15, Md.

17 (a) Burial (b) Date thereof Dec 6 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Seton
Location Seton Institute

18 (a) Funeral director Stewart & Monument Company
(b) Address 108-14 North Ave., Balto 41, Md.

19 (a) DEC 5 - 1947 (b)
(Date rec'd by registrar) Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1947 at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1931, to Dec. 4 1947, and that I last saw her alive on Dec. 4 1947

Immediate cause of death Repeated Coronary Occlusion — Duration

Due to General Arteriosclerosis

Due to

Other Conditions Phychosis with cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James B. Magee M. D.
Address 33 E. Lexington St. Date signed

Space # 13

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 183

Registered No. 65263

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians, please write any information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street.
(c) Hospital or institution: 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Found-
(a) State (b) County Foot of Central Ave
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50-?			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY DEC 4, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 5- 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1947, at 3.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 3-2
(a) Date of injury 11-18-47 at 3 P. M.
(b) Where did injury occur? Foot of Central Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned.

23. Signature Earl L. Kaylor M.D.
Medical Examiner
Date signed 11-19-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

Registered No. 21138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4132 Hague Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifton H. Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Mamie J. Smolka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/3/1917

8. AGE: Years | Months: 7 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Dishwasher

11. Industry or business: W. Md. R.R.

FATHER
12. Name: Wm. J. Green
13. Birthplace: Md.

MOTHER
14. Maiden Name: Charlotte H. Bass
15. Birthplace: Md.

16 (a) Informant: Stepmother
(b) Address: 413 Clarkson St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/8/47
(month) (day) (year)

(c) Cemetery or crematory: Bayview Cem.
Location: 5801 Sinclair Rd.

18 (a) Funeral director: James L. McCauley
(b) Address: 130 S. Fort Ave.

19 (a) DEC 5 1947 (Date received by local registrar) (Huntington Williams, M.D.) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 1947, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Probable Accidental
Gunshot wound of head

Due to

Other Conditions Intoxication

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/3/47 at about 8:30 P.M.
(b) Where did injury occur? 4132 Hague Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Shot self in rt. temple
c. 32 Cal. pistol

23. Signature B. J. Schumacher M.D.
Medical Examiner.

Date signed 12/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

357659
AB-18631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 357659

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 75
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Albert(D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27- 1864

8. AGE: Years 83 | Months | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Isiah Moore
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah J. Atkinson
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel
Location

18 (a) Funeral director Jos. L. Locke & Co.
(b) Address 1304 N. Eastern Ave

19 DEC 5 1947 (b) Funeral Home, Inc., Baltimore, Md.
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5- 1947, at 6:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11- 1933, to 12-5- 1947, and that I last saw h.. alive on 12-3- 1947.

Immediate cause of death	Duration
Cerebral Embolism	1 day
Due to Arteriosclerotic Heart Disease	yrs
Due to	
Other Conditions Uremia Nephrosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: At above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Robinson M. D.
Address Balt City Hosp Date signed 12/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57670

BALTIMORE CITY HEALTH DEPARTMENT

JL - 114519 **CERTIFICATE OF DEATH** 46E

Registered No. 25570

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 51
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Spring Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Claudean LaGrant or Clodine Grant or Claudean Lagran

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1889

8. AGE: Years 57 | Months 11 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Warton
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Hopkins
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 4000 Boundary Ave

DEC 5 - 1947 (Date rec'd by registrar) (b) Huntington Williamsport Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1947, at 7pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1947, to Dec. 5 1947, and that I last saw her alive on Dec. 3 1947.

Immediate cause of death	Duration
Debilitation and Emaciation	4 weeks
Due to Pelvic Abscess	6 weeks
Due to Carcinoma of Sigmoid, Colon	1 year
Other Conditions with Pat. Obstruction	

(Include pregnancy within 3 months of death)

Date of operation 10-17-47, 10-31-47

Major findings of operation: Carcinoma of sigmoid & obstruction & Pelvic abscess

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rush E. Nettleville M. D.

Address Balt. City Hospitals Date signed Dec 4 47

X

657671 Birth Certificate B-45335

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

657671
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The item or information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Doctors Hospital 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2669 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Girl Wolle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Infant

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1947

8. AGE: Years	Months	Days	If less than one day
		2 1	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Edward Wolle
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rhena Johnson
15 Birthplace Lanchester, England

16 (a) Informant.....
(b) Address.....

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School DEC 1947

18 (a) Funeral director..... Commissioner of Health
(b) Address.....

19 DEC 5 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1947, at 12 Midnight

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1947 to Nov 27 1947, and that I last saw her alive on Nov 27 1947

Immediate cause of death..... Duration
prematurity
Due to.....
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ....M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury.....

23. Signature H. W. Wolle M. D.
Address 3971 Edmondson Ave. Date signed 12/3/47

Schedule acc. x

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 157072

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 Fleming Drive #22
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy West

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Eva West (mother)

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 1hr.

8. AGE: Years | Months | Days | If less than one day: 1 hr. min.

9. Birthplace University Hospital
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Calvin West
13. Birthplace Virginia

MOTHER 14. Maiden Name Eva West
15. Birthplace Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 1947

18 (a) Funeral director
(b) Address Commissioner of Health

19 DEC 5 - 1947 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 1947, at 4:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947, to Dec. 1947, and that I last saw h[illegible] alive on Dec 1 1947

Immediate cause of death	Duration
Asphyxia	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. H. Powell Jr., M.D.
M. D.
Address Univ. Hospital Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC #75919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 65263

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Streets
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (23)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Pierce St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Jones

3 (b) If veteran, name war —
(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Newborn

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-22-47

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace University Hosp - Balt. md.
(Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER
12. Name Johnie Jones
13. Birthplace South Carolina

MOTHER
14. Maiden Name Pauline Pendleton
15. Birthplace Richmond, Va.

16 (a) Informant Mother
(b) Address 1704 Pierce St. Balt. (23) Md

17 (a) ____ (b) Date thereof ____
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ____
Location University Medical School DEC 1947

18 (a) Funeral director Commissioner of Health
(b) Address ____

DEC 5 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1947, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1947 to 11-26 1947 and that I last saw him alive on 11-26 1947

Immediate cause of death Respiratory Failure — Duration
Due to Prematurity
Due to ____
Other Conditions ____
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature Wm. L. Lowry M.D.
Address University Hospital Baltimore, Md. Date signed 11-26

Bc 3.95916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 57674

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Brewer St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Frederick
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1947

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Pauline Frederick
15. Birthplace

16 (a) Informant Pauline Frederick
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 5 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1947, at 1 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1947 to Nov 29 1947 and that I last saw h[illegible] alive on Nov 29 1947.

Immediate cause of death	Duration
Asphyxiation	
Due to Aspiration	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos Shear
Address Univ Hosp Date signed 12/9/47

X

657675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 670 Westinghouse Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Gerstley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-25-47

8. AGE: Years | Months: 10 mos. | Days | If less than one day: hr. min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Carl Gerstley
13. Birthplace N.J.

MOTHER
14. Maiden Name ? Carol
15. Birthplace Mass.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Philadelphia, Pa

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

DEC 5 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1947 at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1947 to Dec 4 1947 and that I last saw her alive on Dec 4 1947

Immediate cause of death	Duration
Asphyxia	
Due to Tetralogy of Fallot	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4 Dec 47.

Major findings of operation: Pulmonary Stenosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. D. Spohn Jr. M.D.
Address Johns Hopkins Hospital Date signed 12-7-47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINT WITH PENCIL, WITH UNFADING INK.

B.C.H. A-95571

157676 /

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1158

Registered No. 157676

Every item of information should be carefully written. PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 Wyatte St.
(c) Hospital or institution: Bon Secours Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs 20 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 3
(d) Street No. 1916 Christian St. (If rural give location)
(e) Citizen of foreign country? Not (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Mary Stelling

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/4/42

8. AGE: Years	Months	Days	If less than one day
			2 hr. 20 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Stelling
13. Birthplace Md.

MOTHER
14. Maiden Name Agnes Wenker
15. Birthplace Md

16 (a) Informant Edward Wenker
(b) Address 1916 Christian St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-42 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore, Md

18 (a) Funeral director George A. Farley
(b) Address Baltimore, Fayette St.

19 DEC 5- 1942 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1942, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1942 to 12/5 1942 and that I last saw h[illegible] alive on 12/5 1942

Immediate cause of death Respiratory failure — Duration

Due to

Due to

Other Conditions Failure to respond at birth - cause (?)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul D. Mannion M. D.
Address Bon Secours Hosp. Date signed 12/5/42

G57677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered G57677

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 S. Clinton St
(c) Hospital or institution: 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town State
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 S. Clinton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Matthew Fergusson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, ~~married, widowed or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Oct 31st 1877

8. AGE: Years 70 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Charles Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer - Highway Dept

11. Industry or business City of Balto.

FATHER
12. Name Robert Fergusson
13. Birthplace Charles Co. Md.

MOTHER
14. Maiden Name Elizabeth Davis
15. Birthplace Charles Co. Md.

16 (a) Informant Mrs. J. Morle
(b) Address 3129 Weaver Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/6/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St.

DEC 6 - 1947
(Date rec'd by registrar)

(b) Washington Williams, M.D.

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1947 to Dec 4 1947 and that I last saw h~~im~~er alive on Dec 3 1947.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease	
Chronic Myocarditis	Aug 26 '47
Due to Myocardial Failure	12-4-47
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E A Schumunk M. D.

Address 842 E Eutaw Pl Date signed 12-5-47

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C

Registered No. G57678

G57678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 E. Lombard
(c) Hospital or institution:
3-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Posterk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed or divorced~~: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26- 1892

8. AGE: Years 55 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Mine Worker

FATHER
12. Name Unknown Posterk
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John Tenczar
(b) Address 323 E. Ladvale St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/8/47
(month) (day) (year)
(c) Cemetery or ~~crematory~~ Glen Haven
Location Glenburnie Md.

18 (a) Funeral director William Cook Inc
(b) Address 1317 St. Paul St

19 (a) DEC 6- 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4- 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1947 to 1947, and that I last saw him alive on Dec. 3 1947.

	Duration
Immediate cause of death Decomp. prevented Heart - insufficiency	
Due to Surprised coronary thrombosis	instan
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Kare Tramont M. D.

Address 1623 E. N. Avenue Date signed 12/5/47

VS 150

Every item of information should be carefully supplied. Use typewriter, with UNFADING INK. Erasures not permitted. Do not write over printed matter. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G57679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G57679

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3020 Hamilton Ave
(c) Hospital or institution: 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie G. Wilcox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Elmer E. Wilcox

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 2 187?

8. AGE: Years 75 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Brown
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Maurice E. Wilcox
(b) Address 3020 Hamilton Ave

17 (a) Burial (b) Date thereof 12/6/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) [illegible] (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3rd 1947 at 10'5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Dec 3 1947, and that I last saw HER alive on Dec 3 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	7 days
Due to Cerebral Sclerosis -	
Due to	
Other Conditions Arteriosclerosis Heart disease -	Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Dawson M. D.
Address 4808 Harford Rd. Date signed 12/5/47

VS 150

X

IMPORTANT, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G57680

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 WALBROOK AVE
(c) Hospital or institution:
15 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 WALBROOK AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH AGNUS PHILLIPS

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: JAMES
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 21, 1869

8. AGE: Years 78 | Months 4 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace PENNA.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant Miss SARAH V. DOWLING
(b) Address 3304 WALBROOK AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory LONDON PARK
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address NORTH & PA. AVES. BALTO, MD

19 (a) DEC 6 1947 (Date received by Registrar) (b) Burying for Hillcrest Mem. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 4 1947, at 2:00 NOON M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1947 to Dec. 4 1947, and that I last saw her alive on Dec. 3 1947

Immediate cause of death	Duration
Obstructive jaundice	12 weeks
Due to Obliterative cholangitis	12 weeks
Due to Chronic cholecystitis & cholelithiasis	10 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct. 7, 1947

Major findings of operation: Chronic cholecystitis cholelithiasis; Obliterative cholangitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney R. Gehlert Jr.
Address 133 W. Fayette St. Date signed M. 12 D. 5 47

X

G57681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G57681

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3022 Iona terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Iona Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM EWELL WEBB

3 (b) If veteran, name war: No
3 (c) Social Security Account: 218-05-3875

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Bessie B. Webb
6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Sept. 7, 1885

8. AGE: Years	Months	Days	If less than one day
62	2	26	..... hr. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Clerk
11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: William Webb
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Laura Roberts
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Bessie B. Webb
(b) Address: 3022 Iona Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) DEC 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1947, at 12.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Dec 3 1947, and that I last saw h[im] alive on Dec 1 1947.

Immediate cause of death	Duration
Coronary Thrombosis	(1/3/47)
arterial Hypertension	—
Due to arthritis - 5 years	—
Due to	
Other Conditions Diabetes Mellitus	—

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Louis J. Krumrein M. D.
Address 722 N. Kenwood Ave (Date signed)

94 A 12/4/47

G57682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57682 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city, or town limits, write RURAL and give town)
(d) Street No. 1210 Windemere Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nelson J. Sweglar NELSON JAMES SWEGLAR

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-05-9979

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myrtle L.

6 (c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1901

8. AGE: Years	Months	Days	If less than one day
45 45	11	8	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Estimator

11. Industry or business: Lloyd E. Mitchell, Inc.

FATHER
12. Name: Eugene I. Sweglar
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mabel R. Nixon
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Myrtle Sweglar
(b) Address: 1210 Windemere Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) DEC 6 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/47 19..., at 3:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [illegible], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OR DEATH: Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Peters M.D. Medical Examiner.
Date signed 12/5/47

VS 181

correct age is especially important. Physicians: please write the

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

057683 / 107

Registered No. 057683

057683

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Calvin Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emory W. Childs

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Olivia M. Childs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1868

8. AGE: Years	Months	Days	If less than one day
79	1	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas Childs
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Bond
15. Birthplace Md

16 (a) Informant Lawrence B. Childs
(b) Address 2967 Kenwick Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6/47 (month) (day) (year)
(c) Cemetery or crematory Poplar
Location Balto Co. Md.

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave.

DEC 6 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3, 1947, at 8:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1947, to 19; and that I last saw h[illegible] alive on 19.

Immediate cause of death: Bronchopneumonia — Duration: 5 days
Due to: Cerebral Arterio sclerosis — 5 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Norman R. Klemm M. D.
Address 3803 Edmondson Ave Date signed 12/5/47

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Register 657684

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1352 FREMONT AVE.
(c) Hospital or institution:
PROVIDENT
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1352 N. FREMONT AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET T. HOLLINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FE	N	SGP

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/7/96

8. AGE: Years	Months	Days	If less than one day
51	10	24	hr. min.

9. Birthplace GLOUCESTER, VA.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Hollis ?
15. Birthplace ?

16 (a) Informant Russell T. Hunter
(b) Address 423 Cummings Court

17 (a) Burial (b) Date thereof Dec. 5 '47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director Jno. Ed. H. Holland
(b) Address 1637 Eutaw St. Hillsboro

19 (a) Date rec'd by local reg. (year) (b) Huntington Hillsboro

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1 1947, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1947 to 12/1 1947, and that I last saw h e alive on 12/1 1947

Immediate cause of death Myocardial Insufficiency.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2-3 Mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Preston Hunt M. D.
Address 514 Division Date signed 12/2/47

VS 190

C57685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Register No. C57685

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 Penn Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs.) mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 Penn Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucinnia Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/23/1895

8. AGE: Years 52 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name John L. Smart
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Tubman
15. Birthplace Md

16 (a) Informant Lonie Mc Coy
(b) Address 809 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B & O Co., Md

18 (a) Funeral director Isaiah L Burnett & Son
(b) Address 101 N Montgomery St

19 DEC 6 - 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/1947 at 1:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 to Dec 4 19 47.
and that I last saw alive on Dec 4 19 47.

Immediate cause of death Cerebral Hemorrhage — Duration 3 mos

Due to Arterial Hypertension

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 74 W Penn Date signed 12-6-47

C57686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 A

Registered No. C57688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Terrell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1891

8. AGE: Years 55 56 | Months 2 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Lafe, Virginia (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Henry Terrell
13. Birthplace Va.

MOTHER 14. Maiden Name Anna Carrington
15. Birthplace Va.

16 (a) Informant Anna R. Reid
(b) Address Lafe, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto, Md

18 (a) Funeral director Charles R. Law
(b) Address 803 Madison Ave.

19 DEC 6 - 1947 (Date rec'd by Registrar) (Signature) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1947 at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1947 to 12-3 1947, and that I last saw h.e.r alive on 12-3 1947.

Immediate cause of death	Duration
Intraventricular Hemorrhage	
Due to Cerebro-Vascular accident	
Due to Hypertensive Cardio-Vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-11-47

Major findings of operation: Cerebro-Vasc. Accident & Intra-ventr. Hem.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Hightower M. D.
Address University Hosp. Date signed 12-3-47

VS 190

X

Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

857687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94A

Registered 857687

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 N. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Florentine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Mary Helen Florentine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4th 1907

8. AGE: Years 40 | Months 1 | Days 0 | If less than one day hr. min.

9. Birthplace York Pa.
(Town, county, and state)

10. Usual Occupation Owner

11. Industry or business Restaurant

MOTHER / FATHER

12. Name Henry Florentine

13. Birthplace Italy

14. Maiden Name Mary Luzzie

15. Birthplace Italy

16 (a) Informant Mary N. Florentine

(b) Address 1917 N. Charles St

17 (a) Burial (b) Date thereof 12/8/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cathedral

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 DEC 6 - 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4th 1947, at 2.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 1947 to 12-4 1947 and that I last saw h~~e~~ alive on 12-4 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 1 da

Due to: Coronary Disease — 2 yr

Due to:

Other Conditions: Johnson by Operation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Forest H. Paul Coates

Address 67 Washington Blvd Date signed 12/5/47

X Howard F. Downing, M.D.

VS 150

G57688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G57688

INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3513 Reisterstown Rd.
(c) Hospital or institution:
15 1y
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3513 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rena Schiller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife 1871

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Bosk, Latvia (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER 12. Name Simon Michelson

13. Birthplace Latvia

MOTHER 14. Maiden Name Elka -

15. Birthplace Latvia

16 (a) Informant Mrs. Rena Schiller

(b) Address 3513 Reisterstown Rd. 12-7-47

17 (a) burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location

18 (a) Funeral director Jacob Heine Inc

(b) Address 2107 W. Lexington St.

DEC 6 - 1947 (Date rec'd by registrar) Huntington Williams

V S 150

MEDICAL CERTIFICATION 15

20. DATE OF DEATH 12-5-47 19 , at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-19 1936 to Dec. 4 1947, and that I last saw h alive on Dec. 4 1947.

Immediate cause of death	Duration
Diabetis Mellitus	12 yrs.
Coronary Sclerosis	8 yrs.
Due to arteriosclerosis	
Due to	
Other Conditions Diabetic gangrene	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. A. Michelson M. D.

Address 2230 Eutaw Pl. Date signed 12/5/47

G57689 B.C.H. A. 1424 / 1947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G57689

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Warren Rd. 21 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Brian Joseph Voudroeck

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1947

8. AGE: Years | Months | Days: 20 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name William P. Voudroeck
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bertha Zeberlein
15. Birthplace Baltimore, Md.

16 (a) Informant Bertha Voudroeck
(b) Address 3 Warren Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Lawn
Location Eastern Ave. Rd., Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-5-5 E. Madison St.

19 Dec. 6, 1947 (b) Washington Md. (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1947 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15, 1947 to Dec. 5, 1947. and that I last saw him alive on Dec. 5, 1947

Immediate cause of death: Respiratory failure — Duration
Due to Inanition
Due to Prematurity
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. DiPaula M.D.
Address St. Joseph's Hosp. Date signed 12/6/47

VS 150

G57690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1317

G57690 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4745 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4745 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELSIE H. OPPENHEIMER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Sigmund Oppenheimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1873.

8. AGE: Years	Months	Days	If less than one day
73	11	16	hr. min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Solomon Hecht,
13. Birthplace Germany.

MOTHER
14. Maiden Name Johanna Kuhn,
15. Birthplace Germany.

16 (a) Informant Mrs. Emma Kaufmann,
(b) Address 4745 Park Heights Ave.

17 (a) Burial (b) Date thereof 12/7/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1902 Eutaw Place.

19 (a) DEC 6 1947 (b) Filed by registrar Eutaw Pl. Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1947 at 11.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to Dec 4 1947 and that I last saw h[illegible] alive on Dec 3 1947

Immediate cause of death	Duration
Terminal Pneumonia	48 hrs.
Due to (b) Hypertensive cardio — renal Disease	5 yrs.
Due to (a) Multiple Encephalopathy	4 weeks
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kurt H. Waldfogel M. D.
Address 6919 Harford Rd. Date signed

VS 150

G57691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57691

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7022 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7022 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD LOEWENSON.

3 (b) If veteran, name war

3 (c) Social Security Account No. 559-10-5921

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Estelle L. Loewenson
6 (c) If alive, give age 1898

7. Birth date of deceased (mo., day, yr.) July 17, 1898.

8. AGE: Years	Months	Days	If less than one day
49	4	18	hr. min.

9. Birthplace Vienna, Austria Fredericksburg, Va. (Town, county, and state)
10. Usual Occupation Civil Engineer.
11. Industry or business

FATHER
12. Name Adolph Loewenson,
13. Birthplace Germany.

MOTHER
14. Maiden Name Marie ?
15. Birthplace Germany.

16 (a) Informant Mr. Richard Loewenson, Jr. Loewenson
(b) Address 7022 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.7.47. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Manuel Levine Sons
(b) Address 1902 Eutaw Place.

19 (a) Dec 8 1947 (b)
(Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5th. 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1947 to Dec 5 1947, and that I last saw him alive on Dec 5 1947.

Immediate cause of death	Duration
Coronary thrombosis	1 hr
Due to Coronary artery disease	2 yrs.
Due to Hist of	
Other Conditions Hx of coronary thrombosis x 3 yrs prev. (Include pregnancy within 3 months of death)	attack

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frederick Lantz M. D.
Address Temple Garden Apts Date signed 12/5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G57692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Theresa D. Pate

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/1862

8. AGE: Years	Months	Days	If less than one day
85	8	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Francis J. Dreves
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Farber
15. Birthplace Germany

16 (a) Informant Francis D. Pate
(b) Address 2000 Linden Avenue

17 (a) Burial (b) Date thereof 12/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. W. Meade and Son
(b) Address 805 N. Calvert Street

19 (b) DEC 8 1947 Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1947, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1947 to 12/5 1947, and that I last saw h. ER alive on 12/5 1947

Immediate cause of death Terminal bilateral pneumonia. — Duration

Due to

Due to

Other Conditions Cardiac decompensation (Left sided)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul B. Mannino M. D.
Address Bon Secours Hosp. Date signed 12/5/47

G57693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G57693

Please answer all questions. If information should be carefully supplied. The accuracy of information is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 891- W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David (DANIEL) Newton (LAWOOD) Rhode

3 (b) If veteran, name war World War II

3 (c) Social Security Account No. 160-16-0829

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ethel Irene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, (1902) 1905

8. AGE: Years	Months	Days	If less than one day
42	1	26 25	hr. min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER
12. Name Alfred L. (Kallode) Rhode
13. Birthplace Wash. Co. Md.

MOTHER
14. Maiden Name Clara L. Potter
15. Birthplace Hagerstown, Md.

16 (a) Informant Mrs Clara L. Rhode (Fred Kruss)
(b) Address 691 Highland Ave Hagerstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-47 (month) (day) (year)
(c) Cemetery or crematory Antietam National Cemetery
Location Sharpsburg Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 121 St Paul St

19 (a) DEC 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1947, at 12.10 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [x], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Snyder M.D.
Medical Examiner

Date signed 12-5-47

G57694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B

Registered No. G57694

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH ONFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs. ~~mos.~~ ~~da~~ days) 36
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Ruxton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ruxton and Darnell Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Gaines LEONARD MYRTON GAINES

3 (b) If veteran, name war: World I

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife: Marion B. Gaines

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 20, 1895

8. AGE: Years: 52 | Months: 7 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Richmond Va.
(Town, county, and state)

10. Usual Occupation: Partner

11. Industry or business: Bautz & Gains Contractors

FATHER
12. Name: Geo. Decatur Gaines
13. Birthplace: Richmond, Va.

MOTHER
14. Maiden Name: Maria Connor
15. Birthplace: Lynchburg, Va.

16 (a) Informant: Mr. Wm. Lee Gaines
(b) Address: Ruxton & Darnell Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/47 (month) (day) (year)
(c) Cemetery ~~Accomack~~ Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: North & Pa. Aves. Balto. 17, Md.

19 (a) DEC 6 - 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 4 1947, at 12:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947, to Dec 4 1947, and that I last saw him alive on Dec 4 1947.

Immediate cause of death	Duration
Cardiovascular collaps	
Due to Uremia	2 wks
Due to	
Other Conditions Peritonitis, fecal fistula, ruptured bladder	

(Include pregnancy within 3 months of death)

Date of operation 11/3 + 11/12/47

Major findings of operation: intestinal obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Univ Hospital Date signed 12/7/47

G57695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G57695
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 953 Rosedale St
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 953 Rosedale St.
(If rural give location)
(e) Citizen of foreign country? D (Yes or No)
If yes, name country

3 (a) FULL NAME Ella L. Gladden

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Abel D Gladden

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 4 1863

8. AGE: Years	Months	Days	If less than one day
84	3	1	hr. min.

9. Birthplace Jamestown Hanford co Md
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Thomas H Miller
13. Birthplace Balto co Md

MOTHER
14. Maiden Name Emma Barber
15. Birthplace Jamestown Hanford co Md

16 (a) Informant Mrs Grace E Mullinix
(b) Address 953 Rosedale St Balto Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8-47 (month) (day) (year)
(c) Cemetery or crematory Jamestown
Location Jamestown Md

18 (a) Funeral director Marion Shultz
(b) Address Jamestown Md

19 DEC 6 1947 (Date rec'd by registrar) Hunting for Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5th 1947, at 9.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1947 to Dec 5 1947 and that I last saw h[illegible] alive on Dec 5 1947

Immediate cause of death Uremia cardiac insufficiency Degeneration arterial sclerotic type Heart Disease. — Duration

Due to Multi cardiac thrombosis & Congestive failure

Due to Generalized arteriosclerosis Pulmonary edema.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Michel M. D.
Address 401 Edmondson Date signed Dec 6 1947

VS 150

657696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

657696 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 E. Gittings Ave
(c) Hospital or institution: Dom.
27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 E. Gittings Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stefanie Heckel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife late Eugene F Heckel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1891

8. AGE: Years 56 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Estonia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name —
13. Birthplace Estonia

MOTHER
14. Maiden Name —
15. Birthplace Estonia

16 (a) Informant Mr Arthur F Heckel
(b) Address 610 E Gittings Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Rd

18 (a) Funeral director Harry H Wilyke
(b) Address 4101 Eastern Ave

19 (a) DEC 6 - 1947 (Date rec'd by registrar) Hunter for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1947, at 12:25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Illuminating gas
Due to

Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/5/47 at about 11:00 P.M. 12/4/47
(b) Where did injury occur? 610 E Gittings Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury and nature Gas inhalation from gas oven

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 12/5/47

VS 151

G57697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

114D

G57697

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 326 N. Schroeder St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Stanley Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	Sep.

6 (b) Name of husband or wife Jennie Bagwell Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-9-02

8. AGE: Years	Months	Days	If less than one day
45	yrs 6	25	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business

FATHER
12. Name Add Taylor
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Nellie Gilbert
15. Birthplace Balto. Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) 12-7-1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1947, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1947 to Dec 4 1947 and that I last saw h[illegible] alive on Dec 4 1947

Immediate cause of death Pulmonary edema — Duration 1 hr

Due to Cardiac failure — 1 hr

Due to

Other Conditions Lung abscess R. — 1 yr

(Include pregnancy within 3 months of death)
Date of operation 4 December 47
Major findings of operation: Lung abscess R.U. Lobe
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard D Bush, M.D.
Address Johns Hopkins Hosp Date signed 4 Dec 47

VS 150

AB-109469 G57698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G57698 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1053 N. Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23-1922

8. AGE: Years 24 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Bill Moore
13. Birthplace N.C.

MOTHER
14. Maiden Name Effie Dixon
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 12-6-1947 (month) (day) (year)
(c) Cemetery or crematory
Location Int. Olive, N.C.

18 (a) Funeral director Mrs. Katye R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date received by registrar) (Signature of registrar) Registrar

DEC 1

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2- 1947, at 9.12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26- 1947 to 12-2- 1947 and that I last saw h or alive on 12-2- 1947

Immediate cause of death Tuberculosis of Lungs - far advanced — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G.W. Parks M. D.
Address Balt City Hosp Date signed 12-4-47

FORM WHITE COUNTY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G57699
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 N. Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E. Ellis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Widower

6 (b) Name of husband or wife Daisy Ellis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1887

8. AGE: Years	Months	Days	If less than one day
60	8	16	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)
10. Usual Occupation Theatre Manager
11. Industry or business

FATHER 12. Name James Ellis.
13. Birthplace Richmond, Va.

MOTHER 14. Maiden Name Sallie Young
15. Birthplace Richmond, Va.

16 (a) Informant Miss Mabel Eason
(b) Address 700 N. Appleton St

17 (a) Shipped (b) Date thereof 12-6-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Richmond, Va.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) 1947 (Date rec'd by registrar) (b) Katie R. Williams Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1947, at 5.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1947 to Dec 4 1947, and that I last saw him alive on Dec 4 1947.

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Banfield M. D.
Address 722 N. Eutaw St. Date signed 12/6/47

G57700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

G57700

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Northern Parkway
(c) Hospital or institution: The Mount Convalescent
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NELLIE LEE LARRIMORE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: W

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 2-1868

8. AGE: Years 82 | Months 2 | Days 34 | If less than one day hr. min.

9. Birthplace SCOTTLAND (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name JAMES LEE
13. Birthplace SCOTTLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace SCOTTLAND

16 (a) Informant MARY LEE TAYLOR
(b) Address 1807 POPLAR GROVE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-6-47 (month) (day) (year)
(c) Cemetery or crematory MEAVIT.
Location TALBOT CO. MARYLAND

18 (a) Funeral director John O Mitchell & Son
(b) Address 1900 Eutaw Pl.

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1947, at 11.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1947 to Dec. 6, 1947 and that I last saw h[illegible] alive on Dec. 6 1947.

Immediate cause of death: Cerebral Embolism — Duration: 6 days
Due to: Arteriosclerosis, generalized Chronic Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner
Address 1111 St. Paul St Date signed 12/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS [illegible]

Dr. Lerner - 1111 St. Paul St.

G57701 ✓ X G57701

A59032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55a

Registered No.

IMPORTANT. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Newport News. (If outside city or town limits, write RURAL and give town)
(d) Street No. 44 Maury Ave. Beaconsdale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Gail Dunn

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-44

8. AGE: Years	Months	Days	If less than one day
3	4	9	hr. min.

9. Birthplace Va. (Town, county and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name William B. Dunn
13. Birthplace Pa.

MOTHER
14. Maiden Name Jane Brown
15. Birthplace Pa.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16-1947 (month) (day) (year)
(c) Cemetery or crematory Newport News
Location Newport News, Virginia

18 (a) Funeral director H. Langer & Son.
(b) Address 1619 E. North Ave

19 (a) (Date rec'd by Registrar) (b) Registrar

DEC 20 1947 Washington Matthews, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. - 5 - 1947 at 11 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 1 - 1947 to 12 - 5 - 1947, and that I last saw her alive on 12 - 5 - 1947.

Immediate cause of death	Duration
Adrenal Insufficiency	3 days
Uremia	
Due to Adrenal Tumor	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2 Dec 1947
Major findings of operation: Adrenal Tumor - left
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Pincoffs M. D.
Address Johns Hopkins Hosp Date signed 6 Dec 1947

X

G57702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/24

Registered No. G57702

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dixeland + Rayner Ave
(c) Hospital or institution:
West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 4608 Cleveland Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. West Baltimore General Hos.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nicholas V. Ertel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Merle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19th 1908

8. AGE: Years	Months	Days	If less than one day
39	9	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Skilled Laborer
11. Industry or business Garwood

FATHER
12. Name John A. Ertel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Julia Schroff
15. Birthplace Newark, N. J.

16 (a) Informant Mr. John Ertel, Jr.
(b) Address 1014 McAleer Court

17 (a) Burial (b) Date thereof Dec. 9th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkville
Location Parkville Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1041 St. Paul Street

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5-47 19 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1947 to 12-5 1947 and that I last saw h[illegible] alive on 12-5 1947

Immediate cause of death	Duration
Acute PANCREATITIS	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Benjamin Berdansky M. D.
Address West Balt Gen'l Hosp Date signed 12-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57703 (over) G57703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hospital 22-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 S. Greene St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Orville ~~OVAL~~ THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Horse Dealer

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/8/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location Glenburnie Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Date rec'd by registrar Washington Williamson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1947, at 9.45 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured pelvis

Due to

Other Conditions Laceration of scalp.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-1-47 at 6.30 a. M. 52-00
(b) Where did injury occur? Ritchie Highway-Brooklyn, Anne Arundel Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by auto

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 12-1-47

K.

Please correct any item or information should be carefully supplied. The especially important. Physicians: please write the causes of death clearly and legibly.

G57704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947 G57704

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Maryland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J Betz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Wilhelmina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25th 1901

8. AGE: Years 46 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Self

FATHER
12. Name Michael J. Betz
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara (Unknown)
15. Birthplace Germany

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 8 1947 (Registrar) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4th 1947, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Kelbach M.D. Medical Examiner.
Date signed Dec 4, 1947

VS 151

correct age is especially important. Physicians: please write the

G57705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G57705 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT OR WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 RUXTON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph Greenberg

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-0276

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife Idg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

FATHER
12. Name JACOB
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-7-47 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Phila Rd & HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1900 EUTAW PLACE

(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6-1947, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Dec 1947 to 6 Dec 1947, and that I last saw him alive on 5:45 AM 1947

Immediate cause of death	Duration
Cardio - Respiratory failure	
Due to Ca. Lung	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex H. Lerman M.D.

Address Sinai Hosp Date signed 6 Dec 47

X

G57706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97C

G57706

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5133 CHALGROVE AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5133 CHALGROVE AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MORRIS FRIEDLANDER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife SARAH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name ISRAEL
13. Birthplace RUSSIA

MOTHER
14. Maiden Name HANNAH
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (b) Date thereof 12-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHILA. RD + HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PL.

19 (a) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6-47 19 , at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947, to Dec. 6 1947, and that I last saw h alive on Dec. 4 1947.

Immediate cause of death	Duration
Cardiac Arrest	
Parkinson's Disease	
Due to Parkinson's Disease	4yrs
Due to Generalized Arteriosclerosis, Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Cohen M. D.
Address Marlboro Md. Date signed 12/6/47

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57707 BALTIMORE CITY HEALTH DEPARTMENT G57707

CERTIFICATE OF DEATH 97

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3823 Beehler Ave
(c) Hospital or institution: 78
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3823 Beehler AVe
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Potemken

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Tillie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Bernard Potemken
13. Birthplace Russia

MOTHER
14. Maiden Name UNKown
15. Birthplace Russia

16 (a) Informant Mrs Harry Brownstein
(b) Address 3823 Beehler Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) Registrar

V S 15 DEC. 1 [illegible] Washington Heights, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1947 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1947 to Dec 6 1947 and that I last saw him alive on Dec 6 1947

Immediate cause of death	Duration
Cerebral Arteriosclerosis	2 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manuel Levin M. D.
Address 4818 Reisterstown Rd Date signed Dec 6/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G57708 ✓ 93 D

Registered No. G57708

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 Lyndhurst St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Lyndhurst St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C Hennessy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married~~, widowed, or ~~divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 1874

8. AGE: Years 73 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Housework

FATHER
12. Name Thomas Hennessy
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Forlong
15. Birthplace Ireland

16 (a) Informant Agnes J Hennessy
(b) Address 523 Lyndhurst St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Cathedral
Location Old Frederick Rd

18 (a) Funeral director John C Moran
(b) Address 3000 E Balto St

19 (a) Filed Dec 10 1947 (b) Thurlington Williamson, M.D.
(Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1947 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1947 to 12/6 1947, and that I last saw h~~e~~r alive on 12/6 1947.

	Duration
Immediate cause of death: Acute Congestive Heart Failure	12/6/47
Due to: Hypertensive & Arterio Sclerotic ~~Heart~~ Cardio -	
~~Due to~~: Vascular Disease	5 + years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. E. Roach M.D.
Address 2139 Edmondson Ave Date signed 12/6/47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57709 BALTIMORE CITY HEALTH DEPARTMENT G57709
CERTIFICATE OF DEATH VSD Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PENCIL WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 Hollen Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Hollen Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Anthony Dunn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife Mary Mackin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-1892

8. AGE: Years	Months	Days	If less than one day
55	1	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Office Manager
11. Industry or business

FATHER 12. Name James E. Dunn
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary McCarron
15. Birthplace Maryland

16 (a) Informant Mrs Mary Dunn
(b) Address 509 Hollen R.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3400 E. Balt St. 24

19 (a) DEC 9 1947 (Date received by Registrar) (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1947 at 3:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to December 1947, and that I last saw him alive on Nov 29 1947.

Immediate cause of death Coronary Occlusion Recurrent — Duration: Three Years
Due to Coronary sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frederick J. Hallmeyer M. D.
Address 6100 York Road Date signed Dec 9 '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G57710 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Herbert Appleton Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mrs H.A. Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1867

8. AGE: Years	Months	Days	If less than one day
80	9	11	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Wagner
13. Birthplace Penna.

MOTHER
14. Maiden Name Clara Appleton
15. Birthplace Penna.

16 (a) Informant Mrs. Reese
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8 1947 (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Taylor Station Md

18 (a) Funeral director Henry N. Jenkins Sons
(b) Address 3[illegible] McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Mgr.

VS 150

DEC 7 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1947 to Dec 5 1947, and that I last saw him alive on Dec 5 1947.

Immediate cause of death Pneumonia, lobar — Duration 20 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury
23. Signature Samuel W Bond
Address Union Memorial Hospital Date signed 12/8/47

G57711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G57711
Registered No.

Every item of information should be carefully supplied. The correct age, in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Dor Lucours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 2 Mulvad St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Price

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-18-9025

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Mr. Albert Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/6/96

8. AGE: Years	Months	Days	If less than one day
51	6	29	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Maurice Collins
13. Birthplace Ireland

MOTHER
14. Maiden Name Nora Cavanaugh
15. Birthplace Ireland

16 (a) Informant Josephine Powell
(b) Address Ellicott city Md

17 (a) Burial (b) Date thereof 12-9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director J. O. Haysmithorn
(b) Address Ellicott City Md

DEC 7 1947
(Date rec'd by registrar) Wilmington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1947, at 3:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1947 to 12/5 1947 and that I last saw her alive on 12/5 1947

Immediate cause of death Recurrent intracranial hemorrhage (spontaneous subarachnoid) — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul D. Manion M. D.
Address Dor Lucours Hosp. Date signed 12/7/47

G57712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 518

G57712
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cor[rect] age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3252 Laverton Ave
(c) Hospital or institution: 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3252 Laverton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thurnhuber

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 217-03-9108 A

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Feb 8 1878

8. AGE: Years 69 | Months 9 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Thurnhuber
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Springer
15. Birthplace Germany

16 (a) Informant Katherine Thurnhuber
(b) Address 3252 Laverton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 7 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Mount Olivet Service
(b) Address 3410 Belair Rd.

19 (a) 12-7-1947 (Date rec'd by registrar) (b) Registrar

Burlington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1947 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to Dec 5 1947 and that I last saw h alive on Dec 5 1947.

Immediate cause of death: Cancer of Prostate Metastases — Duration: about 16 mo

Due to: Suppurative pancreatitis

Due to: Cerebral Paralysis Spastic Left

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen Cleckner M. D.
Address 3139 Date signed 12-6-47

G57713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G57713

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County FREDERICK
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy ~~Schafer~~ Shafer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace: Md
(Town, county, and state)

10. Usual Occupation: Baby

11. Industry or business

FATHER
12. Name: Kenneth Shafer
13. Birthplace: Middletown, Md

MOTHER
14. Maiden Name: Miriam Sigler
15. Birthplace: Middletown, Md

16 (a) Informant: Record
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Lutheran
Location: Middletown, Md.

18 (a) Funeral director: Bethell Co.
(b) Address: Middletown Md.

19 DEC 8 1947 (b) Huntington Williams, M.D.
(Date rec'd by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5, 1947, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to Dec 5th 1947.
and that I last saw him alive on Dec 5 1947

Immediate cause of death	Duration
Due to Hydrops Foetalis	
Due to Erythroblastosis Foetalis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. H. Sachs, M.D.

Address Johns Hopkins Hosp. Date signed 6 Dec 47

057714

CERTIFICATE CORRECTED 4-10-50 ~~BALTIMORE CITY HEALTH DEPARTMENT~~

CERTIFICATE OF DEATH 196

Register 057714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County.....
(c) City or town Gate Gate City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 59 (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME (~~Mr.~~) Lucian (~~Blalock~~) Blaylock

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 11-15-1881

8. AGE: Years 66 | Months | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Scott Co., Va (Town, county and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Robert Blaylock
13. Birthplace N.C.

MOTHER
14. Maiden Name Sarah Bright
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery or crematory.....
Location Gate City, Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & P. Aves

19 (a) DEC 8 - 1947 (Date rec'd by registrar) (b)..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1947, at 12-15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1947 to Dec 7 1947, and that I last saw h~~im~~er alive on Dec 7 1947

Immediate cause of death: Cerebral vascular accident — Duration: 16 hrs
Due to: ? Thrombosis of ligated internal carotid artery, left — "
Due to .....
Other Conditions: Hypertension Cardiac enlargement
(Include pregnancy within 3 months of death)
Date of operation 12-3-47
Major findings of operation: AV aneurysm (carotid-int. jugular) left
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Rowena Spencer
Address ~~Gate~~ Gate City Date signed 12-9-47 (M. D.)

Huntington Williams, M.D.

B.C.# G57715 - 2-95576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G57715

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2635 Hollins Ferry Road
(c) Hospital or institution: 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2635 Hollins Ferry Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ——— ——— Foerster

3 (b) If veteran, name war	3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7. 1947

8. AGE: Years	Months	Days	If less than one day
—	—	—	hr. — 3 min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John A. Foerster Jr.
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Rhoda L. Bayles
15. Birthplace Md.

16 (a) Informant John A. Foerster Jr.
(b) Address 2635 Hollins Ferry Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8 1947 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director Mrs. John A. Seufert Son
Edmondson Ave Baltimore, Md

19 (a) DEC 8 1947 (Date rec'd by registrar) Huntington Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1947, at 2 18 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1947 to Dec 7 1947 and that I last saw h'M alive on DEAD ON 19 ARRIVAL

Immediate cause of death	Duration
Undetermined	
Due to	
Due to	
Other Conditions Prematurity (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Earl Pass, M.D. M. D.
Address 4001 Wilkens Ave Date signed 12-7-47

X

G57716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1319

Registered No. G57716

The Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3041 Northern Parkway
(c) Hospital or institution: 27-B
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3041 Northern Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Freda Steel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Lath (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Lath

MOTHER 14. Maiden Name unknown

15. Birthplace Lath

16 (a) Informant Harold Steel

(b) Address 2919 Ellwood Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-8-47 (month) (day) (year)

(c) Cemetery or crematory Balto. Hebrew

Location Jack Lewis Inc

18 (a) Funeral director Jack Lewis Inc

(b) Address 1100 Eastern Ave Baltimore Md

DEC 8 1947 (Date received by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7-1947, at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to Dec 7 1947, and that I last saw h. alive on Dec 6 1947.

Immediate cause of death	Duration
TERMINAL PNEUMONIA	2 days
UREMIA	3 WEEKS
Due to Hypertensive CARDIO-RENAL DISEASE	15 YEARS
Due to also: HYPERTENSIVE ENCEPHALOPATHY	4 WEEKS
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Hirschfeld M. D.

Address 6919 Harford Rd Date signed 12/7/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓54a

Registered No. G57717

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp. 27
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 6
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 38

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7207 Old Harford (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rammes, Clara May
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
F	W	

6 (b) Name of husband ~~or wife~~ Herman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/2/09

8. AGE: Years	Months	Days	If less than one day
38	6	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Gett Smith
13. Birthplace Holland
MOTHER 14. Maiden Name Anna Siegal
15. Birthplace —

16 (a) Informant Herman R. Rammes
(b) Address 7207 Old Harford Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 8 47 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave.
18 (a) Funeral director Howard V. Blight Jr.
(b) Address 6009 Harford Road.
19 (a) DEC 8 1947 (Date received by registrar) (b) ~~Huntington Williams M.D.~~ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Nov 29~~ Dec 5 1947 at 10 45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1947 to 5 Dec 1947, and that I last saw h~~e~~r alive on 5 Dec 1947

Immediate cause of death	Duration
Cardio-Resp Failure	
Due to Glioma, Right Frontal Lobe	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Brain Tumor
of autopsy: Glioma, Rt. Frontal Lobe

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John B Welby M.D.
Address St Joseph Hosp Date signed 5 Dec 1947

VS 150

G57718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58B

Registered No. G57718

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4904 Haddon Ave.
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4904 Haddon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Simpson McMahon

3 (b) If veteran, name war

3 (c) Social Security Account No. 200-14-5235

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1922

8. AGE: Years	Months	Days	If less than one day
25	3	14	hr. min.

9. Birthplace Monongahela, Pa.
(Town, county, and state)
10. Usual Occupation Service Station
11. Industry or business Attentant

FATHER
12. Name Raymond S. McMahon
13. Birthplace Alleganhy (ALLEGHENY) County, Pa.

MOTHER
14. Maiden Name Aileen Jackson
15. Birthplace Fayette County, Pa.

16 (a) Informant Father
(b) Address 4904 Haddon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11-47 (month) (day) (year)
(c) Cemetery or crematory Monongahela
Location Pennsylvania

18 (a) Funeral director Edelworth Funeral
(b) Address 3911 Liberty Heights Ave.

19 DEC 8 (by) (year) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th 1947, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1947, to Dec. 7 1947, and that I last saw him alive on Dec. 6- 1947.

Immediate cause of death	Duration
(1) - Rheumatic Heart Disease - with	
Due to Acute Endocarditis -	18 yrs.
Due to	
Other Conditions - Congenital Heart Disease	24 yrs.

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: - Dr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts Date signed 12/8/47

G57719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓47a

G57719 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mich. (b) County:
(c) City or town: Ludington (If outside city or town limits, write RURAL and give town)
(d) Street No.: 320 S. James St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Simon Syskowski

3 (b) If veteran, name war	3 (c) Social Security Account No.
WWI	385-18-6492

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1890

8. AGE: Years	Months	Days	If less than one day
57	0	18	hr. min.

9. Birthplace: Siwalki Russia (Town, county, and state)
10. Usual Occupation: Fireman
11. Industry or business: Seafarer

FATHER
12. Name: ?
13. Birthplace: Russia

MOTHER
14. Maiden Name: ?
15. Birthplace: Russia

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-47 (month) (day) (year)
(c) Cemetery or crematory
Location: Grand Rapids, Michigan

18 (a) Funeral director: John M. Weber
(b) Address: 401 S. Chester Street

19 DEC 8 - 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5 1947, at 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1947, to Dec. 5 1947 and that I last saw him alive on Dec. 5 1947.

Immediate cause of death	Duration
Carcinoma of larynx with complete obstruction	3 yrs.
with extension to the thyroid	
Due to and tongue, metastases to	
cervical lymph nodes, lungs and	
Due to diaphragm	

Other Conditions: Tracheotomy performed 9/20/46 in USMH, Chicago, Ill.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Jan J. Jakeman
Address: Medical Officer in Charge
F. van Ackeren, Medical Director M. D.
Signed 12/4/47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 923

Registered No. 57720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 344 E. 28th St.
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 344 E. 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Sarah E. Schwartz

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Separated

6 (b) Name of husband or wife Daniel A. Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1880

8. AGE: Years	Months	Days	If less than one day
66	11	11 12	hr. min.

9. Birthplace Westminster, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Cain
15. Birthplace Carroll Co. Md.

16 (a) Informant Mr. Daniel A. Schwartz Jr.
(b) Address 5621 Pilgrim Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) DEC 8 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Dec. 5, 1947, at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1944 to Dec. 5 1947 and that I last saw he alive on Dec. 4 1947.

Immediate cause of death: Bronchopneumonia — Duration 3 days
Due to: Chronic Rheumatic Fever Endocarditis — Duration last known
Due to: Mitral Stenosis and mitral regurgitation — Duration last known
Other Conditions: Congestive heart failure — Duration 3 yrs.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Tickner M. D.
Address 2824 St. Paul St. Date signed 12-6-47

VS 150

G57721
A59292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 125a

Registered No. G57721

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Lyndhurst, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Trevan Penrose.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-28-45

8. AGE: Years	Months	Days	If less than one day
2	4	10	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernest Penrose
13. Birthplace England

MOTHER
14. Maiden Name Edith Tilton
15. Birthplace California

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/8/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Balto. County, Md.

18 (a) Funeral director Wm. J. Tickner & Son Inc
(b) Address North & Pa. Aves, Balto, Md.

19 (a) DEC 8 - 1947 (Date rec'd by registrar) (b) Huntington Hillsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. - 7 - 1947 at 2.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30-1947 to 12-7-1947. and that I last saw him alive on 12-7-1947.

Immediate cause of death: Acute Yellow Atrophy — Duration

Due to: Infectious Hepatitis — 2 weeks

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip D. Wagner M. D.
Address Johns Hopkins Hosp. Date signed 12-7-47

X

G57722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57722

PRESS WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1134 Barclay St.
(c) Hospital or institution: 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ellen Staples

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: Wm. B. Staples
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1871

8. AGE: Years	Months	Days	If less than one day
76	0	11 10	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housework at home
11. Industry or business

FATHER
12. Name Michael McLaughlin
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth McDevitt
15. Birthplace Ireland

16 (a) Informant Mrs. Marie A. Burkhardt
(b) Address 1134 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Rd

18 (a) Funeral director Edgar W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) DEC 8 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1947, at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1947 to Dec 6 1947, and that I last saw her alive on Dec 5 1947

Immediate cause of death	Duration
Myocardial degeneration	3 yrs.
Due to Gynecological Enteroptosis Nervous Exhaustion	yrs.
Due to Cerebral Embolism Hemiplegia	yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilligan & Straughn M.D.
Address 10 E. Biddle St. Date signed 12/10/47

V S 150

X

G57723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √ 61

Registered No. G57723

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Rabel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Sophia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-2-1872

8. AGE: Years	Months	Days	If less than one day
75 ~~74~~	6	22	15 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Rabel
13. Birthplace Germany

MOTHER
14. Maiden Name Annie ?
15. Birthplace – Germany

16 (a) Informant Sophia Rabel
(b) Address 905 E. Biddle St.

17 (a) Burial (b) Date thereof Dec 10, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Edward W. Conklin Sons
(b) Address 924 E. Eager St.

19 (a) DEC 8 - 1947 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1947 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1947 to 12/7 1947 and that I last saw him alive on 12/7 1947.

Immediate cause of death	Duration
Paralytic ileus	
Due to	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M.D.
Address 1400 N. Caroline St Date signed 12/7/47

VS 190

122R

G57724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G57724

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St.
(c) Hospital or institution: Home of Our Lady 25-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [redacted]
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Washburn Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie May McDonald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1880

8. AGE: Years	Months	Days	If less than one day
67	5	23	hr. min.

9. Birthplace Brooklyn, Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name George E. McDonald
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary L. Welch
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mollie G. Sunderland
(b) Address 1604 Frederick Road, Catonsville

17 (a) burial (b) Date thereof 12/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Balto., Md.

19 (a) DEC 9 1947 (b) Huntington Williams, M.D.
(Received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1947, at 12 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1947 to Dec 6 1947 and that I last saw h[illegible] alive on Dec 6 1947.

Immediate cause of death	Duration
Carcinoma of uterus	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Klaveman M. D.
Address 753 W. Fayette St. Date signed

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57725

CERTIFICATE CORRECTED 7-10-52

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1117a

G57725 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5316 Brabant Road
(c) Hospital or institution: 28.4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 5316 Brabant Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leslie C. Parker

3 (b) If veteran, name war: World War 1.
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: Mamie (Avery) Parker
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) June 4, 1886
8. AGE: Years 61 | Months 6 | Days 4 | If less than one day: hr. min.
9. Birthplace N.C.
10. Usual Occupation C.P.A. accountant
11. Industry or business

FATHER
12. Name Franklin D. Parker
13. Birthplace N.C.

MOTHER
14. Maiden Name Ivy Herring Parker
15. Birthplace 5316 Brabant Road N.C.

16 (a) Informant Mamie (Avery) Parker
(b) Address 5316 Brabant Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Franklintown

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) DEC 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1947, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Dec 5 1947, and that I last saw him alive on Dec 5 1947.

Immediate cause of death: Pulmonary Embolism, post operative — Duration: Sudden
Due to Partial Gastrectomy for Gastric ulcer
Due to
Other Conditions Arteriosclerotic heart disease — 2 years
(Include pregnancy within 3 months of death)
Date of operation Nov 10, 1947
Major findings of operation: Gastric ulcer
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo J. Gover M. D.
Address 1 Mallon Ct Dave Date signed 12/6/47

X

G57726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V83a

Registered No. G57726

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hosp. 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1848 Eagle Street
(If rural, give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Virginia Tripp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife James Edward Tripp

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1906

8. AGE: Years 41 | Months 2 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Jessups Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walter Eads
13. Birthplace Jessups, Md.

MOTHER
14. Maiden Name Ella
15. Birthplace Jessups Md.

16 (a) Informant James Edward Tripp
(b) Address 1848 Eagle St.

17 (a) Burial (b) Date thereof Dec. 9 1947.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location.....

18 (a) Funeral director Mrs. Kate R. Wolfgang
(b) Address 322 N. Schroeder St.

19 (a) DEC 8 1947 Huntington Wolfgang, M.D.
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1947 at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage, spontaneous

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Carl L. Reyer M.D.
Medical Examiner.
Date signed.....

057727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 457727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1345 Homestead St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1345 Homestead St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad P. Hohman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Cora F. Hohman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1865

8. AGE: Years 82 | Months 8 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Butcher-retired

11. Industry or business

FATHER
12. Name Conrad P. Hohman
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Kinsley
15. Birthplace Germany

16 (a) Informant Henrietta Jamison
(b) Address 1345 Homestead St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.9,1947 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.,

19 DEC 8- 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1947, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Dec 6 1947 and that I last saw h[illegible] alive on Dec 6 1947.

Immediate cause of death	Duration
Hypertension	1 yr
Due to Cardiovascular Disease	
Due to Uremia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1345 Homestead St. Date signed Dec 8 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 638

Registered No. 657728

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2258 Cecil Ave. M
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2258 Cecil Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Funk

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John F. Funk
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Sept. 1873
8. AGE: Years 74 | Months 2 3 | Days | If less than one day hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: Andrew Kemmerzell
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth --
15. Birthplace: Germany

16 (a) Informant: Mr. Lucker
(b) Address: 2258 Cecil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10/47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Harvey Sons
(b) Address: 1024 Orleans St.

DEC 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: DEC. 7 1947 at 7.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from AUGUST 1946 to DEC. 7 1947 and that I last saw her alive on 6 DEC. 1947

Immediate cause of death	Duration
a CEREBRAL HEMORRHAGE	24 hrs.
Due to ARTERIOSCLEROSIS	
Due to HYPERTENSION	
Other Conditions THYROTOXICOSIS ARTERIOSCLEROSIS (CANCER UTERUS)	30 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: Benjamin Highstaffer M. D.
Address: 121 S. Highland Ave Date signed: 7 Dec. 47

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57729

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3229 Fleet Street
(c) Hospital or institution: 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3229 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melissa A. Zuhn

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John F. Zuhn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 16, 1866

8. AGE: Years 81 | Months 8 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace: Indiana
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Mahlon Vore
13. Birthplace: Ind.

MOTHER
14. Maiden Name: Ada Robb
15. Birthplace: Ind.

16 (a) Informant: Albert Connors
(b) Address: 3229 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Henry Sons
(b) Address: 2024 Orleans St

19 DEC 8 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7/47, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1942 to 12/7 1947 and that I last saw h[illegible] alive on 12/6 1947

Immediate cause of death: Arterio-sclerotic heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 321 Eutaw Ave Date signed 12/8/47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINTING, WITH INKING INK.

C57730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. C57730

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Wolsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
M	W	Widowed

6 (b) Name of ~~husband or~~ wife Antonia Wolsky

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27th 1889

8. AGE: Years	Months	Days	If less than one day
57	11	9	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Womens Hospital

FATHER 12. Name Wolsky

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Cecilia Barrack

(b) Address 2854 Oakley Ave.

17 (a) Burial (b) Date thereof 12/8/47
(Burial, ~~cremation~~, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cedar Hill

Location A.A. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

19 (a) DEC 8 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1947, at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to strangulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury about 12/6/47 unknown M.

(b) Where did injury occur? 1617 Park Ave

(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No

(d) Means of injury Hung self from rope from bed post

23. Signature C.F. Schumacher M.D.
Medical Examiner.

Date signed 12/7/47

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Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 657731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 Luzerne Ave
(c) Hospital or institution: 83

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Luzerne Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Sudbrink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Frank Sudbrink

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2nd 1872

8. AGE: Years	Months	Days	If less than one day
75	6	5	hr. min.

9. Birthplace a. a. Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name (unknown) Butchley
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Hawkins
15. Birthplace Md.

16 (a) Informant Frank Sudbrink
(b) Address 1509 N. Luzerne Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) DEC 8 1947 (Date received by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7th 1947, at 9:30 M

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelfuch M.D. Medical Examiner.
Date signed Dec 7, 1947

VS 151

G57732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G57732 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 85
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard C. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Lydia C. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 2 1872

8. AGE: Years 75 | Months 3 | Days | If less than one day hr. min.

9. Birthplace: Balto. Md
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Octavius Smith
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Annie Mac Williams
15. Birthplace

16 (a) Informant: Bertha Lamb Kin
(b) Address: Northwood Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/47 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: DEC 8-1947 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 6 - 1947 at 1.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 1947 to 12-6 1947, and that I last saw h.im alive on 12-6 1947

Immediate cause of death	Duration
Myocardial Infaction	3 days
Due to Coronary Thrombosis	3 days
Due to -	
Other Conditions Bronchopneumonia	2 days

(Include pregnancy within 3 months of death)

Date of operation -

Major findings of operation: -

of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - While at work?
(Specify type of place)
(e) Means of injury -

23. Signature Morris B. Schreiber M.D.
M. D.
Address 54 S. Fulton Ave Date signed 11-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered 652733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland N.
(b) Street address 419 Calhoun S.
(c) Hospital or institution: 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thornton Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1880

8. AGE: Years	Months	Days	If less than one day
67	2	26	hr. min.

9. Birthplace Essex Co. Va.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Briscoe Smith
(b) Address 1373 Stricker St

17 (a) Burial (b) Date thereof Dec. 16-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. Co.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) DEC 8 1947 (b)
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6, 1947 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 6 1947.
and that I last saw h alive on Dec 6 1947.

Immediate cause of death	Duration
(a) Arteriosclerotic Heart Disease	4 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 77 W Lanvale Date signed Dec 7 1947

Wiley

G57734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 B

G57734 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 W. Biddle Street
(c) Hospital or institution: Provident Hospital 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 W Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose E. Wiley

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John R. Wiley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1 1894

8. AGE: Years 53 | Months March | Days 1st | If less than one day hr. min.

9. Birthplace West Over Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Conrad F. Williams
13. Birthplace West Over Md

MOTHER
14. Maiden Name Maria Fountain
15. Birthplace West Over Md

16 (a) Informant Mary A. Richardson
(b) Address 217 W. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9-47 (month) (day) (year)
(c) Cemetery or crematory Cottage Grove Md
Location West Over Md

18 (a) Funeral director Mrs Geo. Ford Holland
(b) Address 640 Druid Hill Ave

19 (a) DEC 8 1947 (Date rec'd by registrar) (b) Transcription for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6- 1947, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1- 1940, to 12-6- 1947, and that I last saw h[illegible] alive on 12-6- 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertension arteriosclerosis	7 years ?
Due to Chronic Cor Pulmonale.	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis E. Hamm M. D.
Address 2340 Madison Ave. Date signed 12-8-47

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 3

X

657735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓186a

Registered No. 657735

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST
(c) Hospital or institution: ST Joseph's Hospital 9
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 89 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 E 32 ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROLAND G STODDARD (ROLAND GRAHAM STODDARD)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: Hannah D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (~~2-4-47~~) Jan. 4 1858

8. AGE: Years 89 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William Stoddard
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily McCollum
15. Birthplace Maryland

16 (a) Informant Mrs. Emma L. Smith
(b) Address 1636 E. 32nd. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

12/8/47 Copper - J.F. Dow M.D. per - Earl L. Royer M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Dec 1947 at 2 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Dec 1947 to 6 Dec 1947 and that I last saw him alive on 5 Dec 1947.

Immediate cause of death: CARDIO Resp FAILURE — Duration
Due to: ARTERIOSCLEROTIC HEART DISEASE
Due to:
Other Conditions: FRACT RT. Hip
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/6
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 4 Dec at 10 A M
(c) Where did injury occur? Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury FALL - FRACT RT Hip

23. Signature Henry J. Houston M. D.
Address [illegible] Date signed 12/6/47

G57736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G57736

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 Homewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Homewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Wm. P Farrell

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-1218

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24, 1887

8. AGE: Years 60 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Belvedere

11. Industry or business Glass man

FATHER
12. Name Michael Farrell
13. Birthplace Ireland

MOTHER
14. Maiden Name Rosanne Duffy
15. Birthplace Ireland

16 (a) Informant Miss Mary Farrell
(b) Address 1315 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Pete Wiedefeld
(b) Address 900 East Biddle St

19 (a) Dec 8 1947 (Date rec'd by Registrar) (b) Transferred from Williamsport, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1947, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to Dec 5 1947 and that I last saw h[illegible] alive on Dec 5 1947.

Immediate cause of death: Chronic Pulmonary Tuberculosis

	Duration
Due to	3 Yrs.
Due to INCARCERATED Incarcerated left Inguinal Hernia	20 Yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William K Straight M.D.
Address 20 E Biddle St Date signed 12/9/1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G577737 95[illegible] BALTIMORE CITY HEALTH DEPARTMENT G577737
CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital. 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2721 MATTHEWS ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ~~Baby Boy Burgan~~ WM. MICHAEL BURGAN-

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/23/47 11-23-47

8. AGE: Years | Months | Days 13 | If less than one day 15 hr. min.

9. Birthplace St. Josephs Baltimore Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name FRANCIS H. BURGAN
13. Birthplace BALTO. —

MOTHER 14. Maiden Name ELIZ. V. MEEHLING
15. Birthplace BALTO-

16 (a) Informant FRANCIS H. BURGAN (FATHER)
(b) Address 2721 MATTHEWS ST.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-9-47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL.
Location

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT & 22ND

19 (a) Washington Williamson, Mgr. (Date received by registrar)

DEC 8 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1947 at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1947 to 12/7 1947 and that I last saw him alive on 12/7 1947

Immediate cause of death: Cardiorespiratory Failure — Duration 1 hr.
Due to: Pre maturity — 13 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James E. Shottle, M. D.
Address St. Josephs Hosp. Date signed 12/7/47

X

G57738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G57738 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 244 N. Payson St.
(c) Hospital or institution: 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 244 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A Carroll

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Late Dennis Carroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16th 1872

8. AGE: Years 75 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at home

FATHER
12. Name John Eddy
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mrs Mary E. Capps
(b) Address 244 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Catholic Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Coonahan
(b) Address 901-03 Hollins St.

19 (a) (Date received by registrar) (b) Carrollton Ave. Baltimore Md.

DEC 8 1947

V S. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9th 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1947 to Dec. 7 1947; that I last saw h[illegible] alive on Dec. 6 1947

Immediate cause of death Arteriosclerotic Cardiac renal vascular disease — Duration

Due to

Due to

Other Conditions Senility
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Ogden Laughlin M. D.
Address 400 N. Payson St. Date signed 12/9/47

X

G57739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57739

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 W. Fayette St.
(c) Hospital or institution: 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Simone Verderami

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rosa Ramaldis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25th 1873

8. AGE: Years	Months	Days	If less than one day
73	11	12	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Marble Finisher
11. Industry or business Self

FATHER
12. Name Unknown
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mrs. Joseph Verderami
(b) Address 5439 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or cremator Dear Cathedral Cem.
Location 4700 Old Frederick Rd.

18 (a) Funeral director John F. Cunningham
(b) Address 901-03 Hollins St.

19 (a) 1947 DEC 8 (b) Received by registrar Washington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7th 1947, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to 19, and that I last saw h— alive on Oct 15 1947

Immediate cause of death	Duration between onset and death
Acute Cardiac failure	1 week
Due to Ch. Myocarditis	years
Due to Old Age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Timmons M. D.
Address 900 W. Lombard St Date signed 8 Dec. 1947.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 156a

0512240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: SINAI HOSPITAL. 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME MAMIE WEINBERGER.

3 (b) If veteran, name war.....
3 (c) Social Security Account No.....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1869.

8. AGE: Years	Months	Days	If less than one day
78	1	17	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Levi Weinberger.
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Eleanor Wheatfield.
15. Birthplace Balto. Md.

16 (a) Informant Miss. Irene Weinberger.
(b) Address Marlborough Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/47. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Levinson & Son
(b) Address 1902 Eutaw Place.

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1947, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1947 to 12/8 1947, and that I last saw her alive on 12/8 1947.

Immediate cause of death cachexia — Duration .....

Due to bronchopneumonia bilateral — Duration .....

Due to fracture of neck of left femur — Duration .....

Other Conditions generalized arteriosclerosis — Duration .....

(Include pregnancy within 3 months of death)

Date of operation 10/21/47

Major findings of operation fracture of left femoral neck.

of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10/19/47 at 10 A.M.
(c) Where did injury occur? Marlborough Apts (City or town) Balto (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell to floor,

23. Signature Marvin Shapiro M. D.
Address Sinai Hosp. Date signed 12/9/47

Howard J. Sanders, M. D.

G57741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57741

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 N. Curley St
(c) Hospital or institution:
6-

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Basto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis A. Friedel

3 (b) If veteran, name of war No

3 (c) Social Security Account No. 219-16-3370

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Verona S.

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Oct 17 1893

8. AGE: Years 54 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Basto. (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER 12. Name Louis A. Friedel

13. Birthplace ?

MOTHER 14. Maiden Name Margaret ?

15. Birthplace ?

16 (a) Informant Verona S. Friedel

(b) Address 5 N. Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 11 47 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR RD

18 (a) Funeral director MARTIN M. E. DIPPEL'S SONS

(b) Address LOMBARD & ANN STS

19 (a) Dec 8 1947 (Date received by registrar) (b) Huntington Milliner, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1947 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Dec 1947 to 8 Dec 1947, and that I last saw h.m. alive on 8 Dec 1947

Immediate cause of death Coronary Thrombosis acute — Duration 24 hrs.

Due to Chronic Myocardial Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph E. Muse Jr. M. D.
Address 331 W St. Paul St. Date signed 8 Dec 47

V S 150

X

G57742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

Registered No. G57742

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 543 S. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VANCE MEDLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife Estelle Medlin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/16/1890

8. AGE: Years	Months	Days	If less than one day
30	-	20	hr. min.

1917

9. Birthplace Wake Co., N C
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Madison Medlin
13. Birthplace N.C.

MOTHER
14. Maiden Name Rachel Maffin
15. Birthplace N C

16 (a) Informant Herbert Medlin
(b) Address Durham N C

17 (a) Removal (b) Date thereof 12/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Raleigh N C.
Location

18 (a) Funeral director Isaac L Brown & Son
(b) Address

19 (a) DEC 8 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1947, at 11.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 23/2

(a) Date of injury 12-5-47 at 9 P. M.
(b) Where did injury occur? Pier #7- Light St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell 20 feet hole

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12-6-47

VS 191

G57743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 94a

Registered No. G57743

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT WRITE ON THIS LINE FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 N. Dallas St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 N. Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE THOMPSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C	MARRIED

6 (b) Name of husband or wife W. M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28/1904

8. AGE: Years	Months	Days	If less than one day
42	11	9	hr. min.

9. Birthplace BALTO; Md (Town, county, and state)
10. Usual Occupation House Wife.
11. Industry or business

FATHER
12. Name HOWARD THOMPSON
13. Birthplace BALTO; Md

MOTHER
14. Maiden Name JANIE WEST
15. Birthplace BALTO; Md.

16 (a) Informant MARY CRAWLEY
(b) Address 27 N. EDEN ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/9/47 (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location A.N County, Md

18 (a) Funeral director Joseph L. Locke
(b) Address 1304 N. Central Ave

19 (a) [illegible] (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1947, at 3 P. M

21. I certify that death occurred on the date above-stated; that I attended deceased from Nov. 29th 1947 to Dec. 6th 1947 and that I last saw he alive on Dec. 6th 1947

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Calcification of Right Leg + Lung	?
Due to Nephritis	?
Other Conditions Deformity of Left Hip for 30 years	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert A. Lefevre M. D.
Address 822 N. Dallas St Date signed 12/9/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

157744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 157744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison Ave & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Earleigh Heights
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Deavers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired Foreman
11. Industry or business W. B. & A. R. R.

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Deavers
(b) Address Earleigh Heights Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 Dec 1947 (month) (day) (year)
(c) Cemetery or crematory Addison's Chapel
Location Seat Pleasant Md
18 (a) Funeral director Lee G. Leach
(b) [redacted] N. Patterson Park ave
19 (a) (Date rec'd by registrar) (b) Burlington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Dec 1947 at 3:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 4 Dec 1947 to 5 Dec 1947, and that I last saw him alive on 5 Dec 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	1 day
Due to Arterio sclerotic cardio vascular disease	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature G. Allan Dyer
Address Md. Gen. Hosp. Date signed 5 Dec 47

VS 150

B57745

LW 118712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registration No. B57745

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horcher, George Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July-31-1881

8. AGE: Years 66 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Miller (D)
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec 10th 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Pleasant
Location Wyman St. Exit

18 (a) Funeral director Leo S. Leavitt
(b) Address 1700 N. Patterson Park ave.

19 (a) DEC 8 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6- 1947, at 10:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1947, to Dec. 6 1947, and that I last saw him alive on Dec. 6 1947.

Immediate cause of death	Duration
Cardiac decompensation	
Due to Arteriosclerosis.	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Kirkus MD
Address Balto City Hosp Date signed 12 Dec 47

X

G57746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G57746 Registered No.

Type or print. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 N. 41st Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 N. 41st Street (If Rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Marshall

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John M. Marshall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31-1873

8. AGE: Years 73 | Months 11 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John McCabe
13. Birthplace New York

MOTHER
14. Maiden Name Lucinda Post
15. Birthplace New York

16 (a) Informant James F. Mayer
(b) Address 1205 N. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9-1947 (month) (day) (year)
(c) Cemetery or crematory Greenwood
Location Brooklyn, New York

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) DEC 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1947, at 1:45 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1946 to 12/6 1947 and that I last saw her alive on Dec 6 1947.

Immediate cause of death	Duration
Coronary Thrombosis	35 Min.
Due to Arteriosclerotic Cardio-Vascular Disease	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Leuman M. D.
Address 3400 Eastern Ave. Date signed 12/7/47

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G57747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 E. Oliver (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** MARGARET G. Delaney

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William P. DELANEY
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-16-82

8. AGE: Years 65 | Months 9 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER 12. Name WILLIAM C. BURKHARDT
13. Birthplace MARYLAND

MOTHER 14. Maiden Name ANNIE T. KELLY
15. Birthplace MARYLAND

16 (a) Informant MRS. MARY BURKHARDT DUNNIGAN
(b) Address 1724 E. OLIVER ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 W. Mt. Royal Ave

19 DEC 8-1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Dec 1947 at 9 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1947 to 12/6 1947 and that I last saw h alive on 12/6 1947

Immediate cause of death CARDIO-Resp FAILURE — Duration

Due to Cirrhosis of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Cirrhosis of liver

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Houska M. D.
Address St. Jos. Hosp Date signed 12/6/47

VS 150

G57748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1837

Registered No. G57748

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1306 John street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 John street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MARY E. MORRIS

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Widowed

6 (b) Name of husband or wife William J. Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1867

8. AGE: Years	Months	Days	If less than one day
80	7	4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Henry McCabe
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Campbell
15. Birthplace Ireland

16 (a) Informant Mrs. Joseph E. O'Brien
(b) Address 1306 John street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans Son Inc.
(b) Address 118 W. Mt. Royal Ave

19 (Date rec'd by registrar) DEC 8- 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1947, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1947, to 12-7 1947, and that I last saw her alive on 12-7 1947.

Immediate cause of death Pneumonia, Bronchial

Due to Cerebral Hemiplegia

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund Lewis M. D.
Address 3400 Hilton Rd Date signed 12/7/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G57749

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 732 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: KATIE MILES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: William Miles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 27 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Bag Well
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Autry Gland
15. Birthplace Va.

16 (a) Informant Annie Autry Gland
(b) Address 515 N. Parrish St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Port Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St.

DEC 8 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1947, at 2.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhage due to stab wounds of thorax

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury 12-6-47 at ? M.
(b) Where did injury occur? 732 N. Gilmor St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument

23. Signature Earl Kyer M.D. (Medical Examiner)
Date signed 12-8-47

657750 LACHOWSKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 657750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antone Lachowske

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Katherine
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1890

8. AGE: Years	Months	Days	If less than one day
57	-	24	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER — 12. Name Lachowski
13. Birthplace Bialystok, Poland

MOTHER — 14. Maiden Name Antonyszyn
15. Birthplace Poland

16 (a) Informant Katherine Lachowski
(b) Address 1616 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Samuel Road

18 (a) Funeral director M. J. Sadowski & Sons
(b) Address 1808 Eastern Ave

19 (a) DEC 8 - 19[illegible] (Received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6 1947 at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5 1947 to 12-6 1947 and that I last saw h[illegible] alive on 12-6 1947.

Immediate cause of death Intracranial hemorrhage - probably subdural hematoma

Duration

Due to

Due to

Other Conditions Pulmonary Tuberculosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address 1400 N. Caroline St. Date signed 12-6-47

83a

G57751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓170c

Registered No. G57751

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE, MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 E. MONTGOMERY
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nora McWayne

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - JULY 26, 1920

8. AGE: Years	Months	Days	If less than one day
27	4	11	hr. min.

9. Birthplace - SUTTON W VA.
(Town, county, and state)

10. Usual Occupation - MEAT PACKING

11. Industry or business -

FATHER
12. Name - THOMAS McWAYNE
13. Birthplace - SUTTON W VA.

MOTHER
14. Maiden Name - ETTA HENDERSON
15. Birthplace - UNKNOWN

16 (a) Informant - MRS. BLANCHE RUBINO
(b) Address 404 HANOVER ST.

17 (a) BURIAL. (b) Date thereof 12 11 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory FAMILY LOT.
Location SUTTON W. VA.

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 DEC 8 - 19[illegible] (b) Huntington Williams, M.D.
(Date rec'd by Local Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Dec 1947, at 11 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions Laceration of scalp. AVULSION OF SCALP
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6 Dec at 3:25 A.M. (Estim. time)
(b) Where did injury occur? Rt. #7 Huntington, W.Va.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? —
(d) Means of injury Struck by motor vehicle

23. Signature Earl L. Ryder M.D.
Medical Examiner.
Date signed 7 Dec 47

X

G57752

GABORIAUd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. G57752

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Laboriaud

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Minnie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1867

8. AGE: Years	Months	Days	If less than one day
80	8	16	hr. min.

9. Birthplace France (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace France

MOTHER
14. Maiden Name Unknown
15. Birthplace France

16 (a) Informant Mrs Jane Hines
(b) Address 204 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore
18 (a) Funeral director George A. Foley
(b) Address Baltimore & Fayette St.

DEC 8 1947 (b) Transcription from Williamsport, Md.
(Local rec'd registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1947 at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Dec. 5 1947 and that I last saw him alive on Dec. 4 1947

Immediate cause of death Arteria-sclerotic Cardio renal Vascular disease — Duration

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Deane Langfitt M. D.
Address 408 N. Payson St. Date signed 12/6/47

X

G57753 BALTIMORE CITY HEALTH DEPARTMENT G52253

CERTIFICATE OF DEATH 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2340 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2340 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIA YINGLING DORSCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife (Nate Baltimore) Dorsch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1861

8. AGE: Years	Months	Days	If less than one day
86	9	5	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John Wear
13. Birthplace Germany

MOTHER
14. Maiden Name — Seiple
15. Birthplace Germany

16 (a) Informant Mrs Bertha Schmidt
(b) Address 14 S Prospect Ave

17 (a) Burial (b) Date thereof Dec. 10 '47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westerly
Location Edmondson Ave & Longwood Sts

18 (a) Funeral director Henry H. Withe
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 8 1947 Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 8 1947 and that I last saw he alive on 12/7 1947

Immediate cause of death	Duration
Bronchopneumonia	5 days
Due to	
Due to	
Other Conditions Arterial Sclerosis Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas W Cahn M. D.
Address 2145 W Belvedere Date signed 12/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Jaeger G57754 Registered No. 97

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Gen. German Aged Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lily Jaeger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24, 1863

8. AGE: Years	Months	Days	If less than one day
84	2	13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eberhardt Wiesner
13. Birthplace Germany

MOTHER
14. Maiden Name Regina Hausner
15. Birthplace Md

16 (a) Informant Gen'l German Aged Home
(b) Address 225 Saint Ave

17 (a) Burial (b) Date thereof Dec 9 '47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westerly
Location Edmondson Ave & Longwood

18 (a) Funeral director Harry H Weyler
(b) Address 4101 Edmondson Ave

19 (a) (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7 1947 at 345 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1947 to 12-7 1947 and that I last saw h[illegible] alive on 12-7 1947

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C B Nauss M. D.
Address Mercy Hosp Date signed 12-7-47

DEPS 820

G57755 BALTIMORE CITY HEALTH DEPARTMENT G57755
CERTIFICATE OF DEATH ✓106B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 792 W. Cross St.
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 792 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael J. Higgins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1875

8. AGE: Years 72 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Higgins
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Burns
15. Birthplace Ireland

16 (a) Informant Leo Hellman
(b) Address 792 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry A. Ritzfe
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5/47 19, at 5:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4th 1947 to Dec 5 1947, and that I last saw h[illegible] alive on Dec 5th 1947

	Duration
Immediate cause of death: Auricular Fibrillation	1 day
Due to:	
Due to: Chronic Bronchitis	10 yrs
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo Hellman M. D.
Address 517 Scott St Date signed 12-6-47

G57758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G57758 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4506 Frederick Rd.

(c) Hospital or institution: Colonial Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2018 Booth St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Evelyn B. Clarke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1892

8. AGE: Years	Months	Days	If less than one day
55	1	14	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name Chas. E. Clarke

13. Birthplace

MOTHER 14. Maiden Name Sarah A. Robinson

15. Birthplace

16 (a) Informant Mrs. Ida Wehrme

(b) Address 2018 Booth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9/47 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn, Md.

18 (a) Funeral director Harry H. Withe

(b) Address 4101 Eastern Ave.

19 (a) (Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7/47 19 , at M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 15 19 to 12/6/47 19 , and that I last saw her alive on 12/6/47 19 .

Immediate cause of death	Duration
(a) Cerebral Thrombosis due to	1 day
(b) Endocarditis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. F. Forster M. D.

Address Woodlawn Md. Date signed 12/7/47

X

G57757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G57757
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 W. Fayette St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Leonard Elliot Cannon

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex 31 M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frances Virginia Cannon
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) March 9 1916

8. AGE: Years 31 | Months 9 | Days 9 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore City, Md
(Town, county, and state)

10. Usual Occupation Caulker

11. Industry or business —

FATHER
12. Name George Cannon
13. Birthplace Norfolk - Va -

MOTHER
14. Maiden Name Minnie Wolf
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs Frances Cannon
(b) Address 1313 W Fayette St

17 (a) Cremation (b) Date thereof Dec 9, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3701 Frederick Ave

18 (a) Funeral director Harry A Wetzler
(b) Address 4101 Edmondson Ave

19 (a) [illegible] (b) [illegible]
(Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 December 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1947 to 12/9 1947, and that I last saw h.im alive on 12/7/1947.

Immediate cause of death Uremia — Duration
with Anuria, Primary
Bronchopneumonia
Due to Diabetic Coma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy Bronchopneumonia bilateral Parenchymatous Kidney (Nephrosis)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 12/11

X

G57758

Found :- Pennsylvania Station

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓159

Registered No. G57758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11>
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown White Newborn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/4/47

8. AGE: Years | Months | Days | If less than one day: hr. 5 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School DEC 1, 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) DEC 8 1947 Huntington Williams M.D.

VS 151 - 47

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1947, at 10 A.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital atelectasis

Due to prematurity

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. TYPE OR PRINT PLAINLY, WITH UNFADING INK.

G57759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57759 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2426 W. Franklin St.
(c) Hospital or institution: 20-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2426 W. Franklin St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian G. Swigert

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Charles Robert Swigert
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1866

8. AGE: Years	Months	Days	If less than one day
81	2	6	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name William Colley
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Hearn
15. Birthplace Howard County Md.

16 (a) Informant Mrs. Ursula Marshall
(b) Address 2105 Hollins St.

17 (a) Burial (b) Date thereof 12-9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director George L. Schwartz
(b) Address 2101 Frederick Ave.

19 DEC 9 - 1947 (b) Huntington Williams M.D.
(Signature of registrar)

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1947, at 20. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1943, to Dec 5 1947, and that I last saw h- alive on Nov 28 1947.

Immediate cause of death Arteriosclerotic Cardio-renal Disease — Duration

Due to — Duration

Due to — Duration

Other Conditions Gradual Senility — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Schwartz M.D.
M. D.
Address 2302 Edmondson Ave Date signed 12/6/47

G57760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G57760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Balto. General Hosp.
(c) Hospital or institution: 204
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2216 Frederick Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Warren Everett Pearman

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frieda A. Pearman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1908

8. AGE: Years 39 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Richmond, Virginia (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Self

FATHER
12. Name Moses Chnell
13. Birthplace Virginia

MOTHER
14. Maiden Name Betty Clemm
15. Birthplace Virginia

16 (a) Informant Frieda A. Pearman
(b) Address 2216 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave

DEC 9 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Dec. 6 1947, at 8:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1947, to Dec. 6 1947, and that I last saw him alive on Dec. 5 1947.

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature DeWitt Laughlin
Address 400 N. Payson St. Date signed 12/7/47 M.D.

G57761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G57761 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fremont & Greene
(c) Hospital or institution: Provident Hospital 4-L
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 W Fayette St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roman R. Rae (Rea)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) ~~Single, married~~, widowed, or divorced. Widowed
6 (b) Name of ~~husband or~~ wife Mary T. Rea
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 28th 1883
8. AGE: Years 64 | Months 10 | Days 9 10 | If less than one day hr. min.
9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Iron Moulder
11. Industry or business
12. Name Luther M. Rea (FATHER)
13. Birthplace Alabama (FATHER)
14. Maiden Name Katherine (Unknown) (MOTHER)
15. Birthplace " (MOTHER)
16 (a) Informant William F. Rea
(b) Address 622 W. Fayette St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.
19 (a) DEC 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1947, at 5 A. M
21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1947 to 12/7 1947 and that I last saw him alive on 12/7 1947
Immediate cause of death Shock — Duration
Due to Acute myocardial infarction supervening
Due to Dr. Ld influenza
Other Conditions Generalized arteriosclerosis; Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature O'Shields M.D.
Address Union Hosp. Date signed 12/11/47

94a

G57762 — 57762 — 6577762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G57762

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Aboard-S.S.Oremar
(a) State Maine (b) County
(c) City or town Portland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 Quebec St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CORNELIUS BARROWS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 14th 1905

8. AGE: Years	Months	Days	If less than one day
41	11	23	hr. min.

9. Birthplace Phila. Pa.
(Town, county, and state)
10. Usual Occupation U.S.S. Merchant Marine
11. Industry or business Bethlehem Steel

FATHER
12. Name Cornelius Barrows
13. Birthplace Providence R.I.

MOTHER
14. Maiden Name Mary Oglehurst
15. Birthplace Somerset Pa.

16 (a) Informant Mary Phillips
(b) Address Calumet, Mass.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/9/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 DEC 9 - 1947 (Date rec'd by Registrar) (Signature of Registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1947, at 3 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture, Dislocation Cervico-Dorsal Vertebrae with injury to Spinal Cord.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 22/1
(a) Date of injury 12-7-47 at 12 a. M.
(b) Where did injury occur? Pier #5- Pratt St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from ladder.

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12-8-47

G57763 52263 X G57763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓183

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Liverpool, England
(a) State Md (b) County Balt.
(c) ~~City or~~ town Annapolis (If outside city or town limits, write RURAL and give town)
(d) Street No. 61 Annapolis Rd (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country England

3 (a) FULL NAME DANIEL O ' CALLAGHAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Ruby O'Callaghan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
29			hr. min.

9. Birthplace Ire. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business British M. V. Empire MacKendrick

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant British Consul
(b) Address Light & Redwood Sts.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/9/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 9 - 1947 (Date rec'd by registrar) (b) Clinton Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1947, at 1.55 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were
IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-7-47 at 1 a. M.
(b) Where did injury occur? Port Covington, Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Found-floating in water

23. Signature [signature] M.D. Medical Examiner
Date signed 12-8-47

X

G57764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57764 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: West Balto Genl. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2503 Lakeland Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John A. Collins

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-4730

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Male	White	Married

6 (b) Name of husband or wife Louise Collins
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 6 1885

8. AGE: Years	Months	Days	If less than one day
62	1	1	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Md Glass Cork

FATHER
12. Name George W. Collins
13. Birthplace Ga

MOTHER
14. Maiden Name Johanna Pfister
15. Birthplace Germany

16 (a) Informant Mrs Louise Collins
(b) Address 2503 Lakeland Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or crematory Westfield
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

DEC 9 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1947, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7 1947 to 12/7 1947 and that I last saw h.IM alive on 12/7 1947.

Immediate cause of death	Duration
PERIPHERAL CIRCULATORY COLLAPSE	
Due to CORONARY INSUFFICIENCY	
Due to CORONARY ARTERIOSCLEROSIS + MYOCARDIAL FIBROSIS	
Other Conditions CARDIAC DECOMPENSATION (Include pregnancy within 3 months of death)	

Date of operation.....
Major findings of operations:.....
Findings of autopsy CORONARY ARTERIOSCLEROSIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Albert Entwistle M.D.
Address West Balto Genl Hosp Date signed 12/7

X

G57765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G57765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore #6 Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 63 Manor Place-
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: GEORGE PEARMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Magdalene Pearman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1st, 1885

8. AGE: Years 62 | Months 10 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Gas & Electric Co.

11. Industry or business: Retired

FATHER
12. Name: George E. Pearman
13. Birthplace: W. Va.

MOTHER
14. Maiden Name: Johanna E. Wright
15. Birthplace: Va.

16 (a) Informant: Mrs. Barbara Crowley
(b) Address: 421 N. Bradford St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: Leasen Funeral Home
(b) Address: 7401 Belair Rd.

19 (a) DEC 9 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at 9.40P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Due to:

Other Conditions: Fracture both femurs, Pelvis & Ribs
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12- 7-47 8 P. M. 62th St. Pulaski Highway
(b) Where did injury occur? Maryland
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian-struck by truck

23. Signature: Earl L. Kaylor M.D.
Medical Examiner.
Date signed 12-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G5776b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓1642

G5776b Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Gough Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK ICHNIOWSKI

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1902

8. AGE: Years 45 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Groceryman

11. Industry or business Self

FATHER
12. Name Simon
13. Birthplace Poland

MOTHER
14. Maiden Name M. Polek
15. Birthplace Poland

16 (a) Informant Frances Ichniowski
(b) Address 1719 Gough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave.

DEC 9 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7/47 19 at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Strangulation
(Asphyxia)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/7/47 at 4:00 P.M.
(b) Where did injury occur? 1719 Gough Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self Inflicted - Hanging

23. Signature John R. Weis, M.D.
Medical Examiner.
Date signed 12/8/47

G57767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 49a

Registered No. G57767

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton + Wilkens Ave. 514 Rock Glen Rd

(c) Hospital or institution: St. Agnes Hosp. 28-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County U. S. A.

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 514 Rock Glen Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Adele Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1890

8. AGE: Years 56 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Schaefer

13. Birthplace Germany

MOTHER 14. Maiden Name Dora Walling

15. Birthplace German

16 (a) Informant Mrs Dora Walling

(b) Address 514 Rock Glen Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10-1947 (month) (day) (year)

(c) Cemetery or crematory London Park Cem

Location Balto md

18 (a) Funeral director A Riley Slade

(b) Address 1907 York Road

DEC 9 1947 (Date received by Registrar) (By) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1947 at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Dec 1947 and that I last saw her alive on Dec 6 1947

Immediate cause of death Generalized Peritonitis secondary to perforated Duodenal Ulcer | Duration

Due to:

Due to: Pneumonia, right lung, explored and found to be

Other Conditions Left ovary and tube adherent to intestine & side wall

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Vernon Jr. M. D.

Address St. Agnes Hospital Date signed Dec 7, 1947

G57768 444860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓97

Registered No. G57768

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL S.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Waldo, Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William White
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-97

8. AGE: Years	Months	Days	If less than one day
50	4	4	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry or business

FATHER
12. Name " White
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md

18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Brantley ave

19 DEC 9 - 1947 (Date rec'd by registrar) (by) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. - 6 - 1947, at 12 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5- 1947, to 12-6- 1947, and that I last saw him alive on 12-6- 1947.

Immediate cause of death	Duration
Heart Failure	
Due to Prolonged Hypoglycemia	
Due to Insulin Reaction	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman M. Mellinkoff M.D.
Address Johns Hopkins Hosp Date signed 12/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57769
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-1
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry (Hooey) Hoey

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-3681

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Cecelia Hoey
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Dec 15-1907

8. AGE: Years	Months	Days	If less than one day
39 SAT	11	22	....hr. ....min.

9. Birthplace Long Green Md
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name William Hoey
13. Birthplace Long Green Md

MOTHER
14. Maiden Name Mammie ?
15. Birthplace Long Green Md

16 (a) Informant Cecelia Hoey
(b) Address 1211 Harlem ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem
Location Long Green, Md

18 (a) Funeral director Eleazer O. Wilson
(b) Address 1010 Brantly ave

19 (a) DEC 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams Md

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1947, at 3:00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ....at.... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. A. Luhrs M.D.
Medical Examiner.
Date signed 12/7/47

G57770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G57770

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. CAROLINE St. 26
(c) Hospital or institution:
ST JOSEPHS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 58 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 76 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 S. LEHIGH St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FILLIUS, JAMES A.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MARGARET
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1871

8. AGE: Years	Months	Days	If less than one day
C 76			hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation PENSIONER - BTC.
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Francis C. Fillius
(b) Address 633 S. Lehigh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext.

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 DEC 9 - 1947 (Date rec'd by registrar) (b) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8 1947, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1947 to 12/8 1947, and that I last saw h/her alive on 12/8 1947

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to CARCINOMA, SIGMOID E METASTASES + PNEUMONIA	
Due to RIGHT LUNG	
Other Conditions LEFT ILIAC VEIN THROMBOSIS	

(Include pregnancy within 3 months of death)

Date of operation 10/20/47

Major findings of operation: CARCINOMA SIGMOID

of autopsy CARCINOMA SIGMOID LUNG METAST

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry A. Carter M. D.
Address St. Jo Hosp Date signed 12/5/47

G57771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1178

G57771

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country – – –

3 (a) FULL NAME EUGENE LAIRD

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary Bauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-14-1886

8. AGE: Years 61 | Months 6 | Days 1 | 5 | 24 | 20 | If less than one day – hr. – min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Fireman
11. Industry or business –

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Frank Laird (son)
(b) Address 719 S. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-47 (month) (day) (year)
(c) Cemetery or crematory Baetz National
Location Fredrick Ave.

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 (a) 9 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1947, at 8 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Perforated ulcer of duodenum, with generalized
Due to purulent peritonitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/5/1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G57772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 S. Rochester Pl.
(c) Hospital or institution: — None — 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Rochester Pl. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME Henry G. Streckfus

3 (b) If veteran, name war: World War I
(c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Tribull
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1891

8. AGE: Years 56 | Months 2 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Fireman
11. Industry or business Pensioned

FATHER
12. Name Henry Streckfus
13. Birthplace ?

MOTHER
14. Maiden Name Barbara Faher
15 Birthplace ?

16 (a) Informant Anna Streckfus
(b) Address 114 S. Rochester Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Ext.

18 (a) Funeral director Lilly & Zeifer Inc.
(b) Address 403 S. Wolfe St.

19 (a) DEC 9 - 1947 (Date received by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1947, at 12:10 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Dec. 7. 1947, and that I last saw h IM alive on Dec. 7 1947

Immediate cause of death: Chr. Myocarditis — Duration
Due to: Arteriosclerosis.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Faher, M. D.
Address 441 S. Elwood Av Date signed 12/9/47

X

G57773 Traugott 1623 E. North Ave. ✓ G57773

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G57773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Ellicasen Nursing Home 14-1
(d) Length of stay in ~~hospital or~~ inst. (yrs., mos., or days) 1 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Mc Mechen St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Eagleton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Music Teacher

FATHER 12. Name William Eagleton
13. Birthplace Tenn.

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Eva G. Baker
(b) Address 1001 St. Paul St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/9/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 DEC 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16th 1947 to Dec. 7 1947 and that I last saw h~~er~~ alive on Dec. 1st 1947.

Immediate cause of death	Duration
Coronary Thrombosis	about 4 weeks
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hare Traugott

Address 1623 E. N. Ave. Date signed 12/9/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A557774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C512774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4633 Harcourt Rd
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4633 Harcourt Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Earl Hughes King

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-833

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife May.

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Nov 21, 1898

8. AGE: Years 49. | Months 9 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business J. H. Cushman & Co

FATHER
12. Name Harry King
13. Birthplace Balto Co.

MOTHER
14. Maiden Name Mary Hughes
15. Birthplace Balto Co.

16 (a) Informant Mrs May King
(b) Address 4633 Harcourt Rd

17 (a) Burial (b) Date thereof 12-9-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location

18 (a) Funeral director J. Kemp Lynch & Son
(b) Address 6067 Harford Rd

DEC 9 - 1947 (b) Hunterston Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1947, at 6 35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1947 to Dec. 6 1947 and that I last saw him alive on Dec. 6, 1947.

Immediate cause of death	Duration
(a) Acute Myocardial infarction	years
Due to (b) Hypertensive Cardio Vas Cular disease	6 mos
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl Hughes M.D.
Address 7007 E. Fratt St. Date signed 12/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

85

G57775
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 64
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILLIP COHEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 34 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Fannie
15. Birthplace Austria

16 (a) Informant Louis Cohen
(b) Address 1836 E Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-47 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 260 Eutaw Place

19 DEC 9 - 1947 (Date rec'd by registrar) by [illegible] for Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at 8.10 a M

21. I certify that I took charge of the remains described above, held an insp.&inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Epilepsy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner

Date signed 12-8-47

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 65776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mt Royal Hotel (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Philip Lyons

3 (b) If veteran, name war

3 (c) Social Security Account No. 185-09-6180

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
56	9		hr. min.

9. Birthplace Latvia (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name unknown
FATHER 13. Birthplace Latvia

MOTHER 14. Maiden Name unknown
MOTHER 15. Birthplace Latvia

16 (a) Informant D. Joseph
(b) Address 11 E Lexington St

17 (a) Burial (b) Date thereof 12-9-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Ohel Shalom
Location O'Donnell St

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eastern Place

DEC 9 1947 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1947, at 11:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1947, to Dec 8 1947, and that I last saw him alive on Dec 8 1947.

Immediate cause of death Cachexia
intestinal obstruction
jaundice
Due to Carcinoma of sigmoid
metastases to liver +
Due to adrenals

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov 28

Major findings of operation: Carcinoma of sigmoid - metastases to liver

of autopsy same

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Ann Shapiro M. D.
Address Sinai Hospital Date signed 12/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G577777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G5'27'77

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Severna Park (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LYDIA WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace A.A. Co. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Horney
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah (unknown)
15. Birthplace

16 (a) Informant James White
(b) Address Severna Park.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Carpenters Hill
Location Jones Station, Md

18 (a) Funeral director J. B. Johnson
(b) Address Annapolis, Md.

19 (a) DEC 9 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at 9.40 P M

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryon M.D. (Medical Examiner.)
Date signed 12-9-47

G57778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G57778
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1341 Sargeant St.
(c) Hospital or institution: 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1341 Sargeant Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA D. KOETHE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Elmer R. Koethe
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 19, 95

8. AGE: Years	Months	Days	If less than one day
52	8	18	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Hamlin
13. Birthplace Md.

MOTHER
14. Maiden Name Carrie Clayman
15. Birthplace Md.

16 (a) Informant Mr. Elmer R. Koethe, husband
(b) Address 1341 Sargeant St.

17 (a) Burial (b) Date thereof 12/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 9 - 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1947, at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1945 to Dec 7 1947 and that I last saw her alive on Dec 6 1947.

	Duration
Immediate cause of death Chronic Myocarditis and myocardial degeneration	5 years
Due to Diabetes Mellitus	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P. Unlock, Jr
Address 1227 Work. Blvd Date signed 12/8/47

X

G57779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G57779

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2111 Dukeland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Relay (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Rolling Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH M. SCOTT

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife T. Parkin Scott, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1886

8. AGE: Years	Months	Days	If less than one day
60	11	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Albert I. Helfrich
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Barbara Basel
15. Birthplace Germany

16 (a) Informant Mrs. Robert M. Scott, sister
(b) Address 2111 Dukeland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 DEC 9 1947 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

VS 18a 11 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1944 to Dec 6 1947 and that I last saw h[illegible] alive on Dec 5 1947

Immediate cause of death	Duration
Coronary Thrombosis Ventricular Fibrillation	2 hours
Due to Arteriosclerotic Cardiovascular disease	
Due to Aortic stenosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Raymond Peters M. D.
Address 1127 N. Calvert St Date signed 12/9/47

G57780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G57780

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Ln
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Cannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1866

8. AGE: Years	Months	Days	If less than one day
81	2	19	hr. min.

9. Birthplace Philadelphia Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stephen Cannon
13. Birthplace

MOTHER
14. Maiden Name Jane McCann
15. Birthplace

16 (a) Informant Wife Sister Son
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E Biddle St

19 DEC 9 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1947, at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 - 1947 to Dec 7 - 1947 and that I last saw him alive on Dec 5 - 1947

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Coronary - Thrombosis	3 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gil Hall M. D.
Address 1631 E North Av Date signed Dec 8-47

C57781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. C57781

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Room 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John L Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W

6 (b) Name of husband or wife Julia Jaworski (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11 1872

8. AGE: Years	Months	Days	If less than one day
75	9 10	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name John Bennett
13. Birthplace

MOTHER 14. Maiden Name Anna
15. Birthplace

16 (a) Informant Ellen Sister of the Dec
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E Biddle St

DEC 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1947, about at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Dec 6 1947, and that I last saw him alive on Dec 5 1947.

Immediate cause of death	Duration
Metastatic Carcinoma Lungs	2 mos.
Due to Carcinoma of Larynx	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 Fordham Date signed Dec 8-47

X

G57782 115876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G57782

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimlre City Hospitals 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 N. Freemont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Louise Spady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.1- 1931

8. AGE: Years	Months	Days	If less than one day
16	11	5	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Major ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 DEC 9- 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6- 1947 at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1947 to Dec. 6 1947, and that I last saw her alive on Dec. 6 1947.

Immediate cause of death	Duration
Tuberculous Peritonitis	
Due to Miliary Tuberculosis	
Due to	
Other Conditions Pulmonary T.B. & Pleural effusion (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elmer R. Henderson M.D.
Address Balto City Hosp Date signed 12-7-47

G57783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57783
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Nanticooke Avenue
(c) Hospital or institution: 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Nanticooke Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE HERBERT RICHARDS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ida M. Richards
6 (c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): January 21, 1886
8. AGE: Years: 61 | Months: 10 | Days: 16 | If less than one day: 17 hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Produce Man
11. Industry or business

FATHER
12. Name: William Richards
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Georganna German
15. Birthplace: Maryland

16 (a) Informant: Mrs. Ida M. Richards
(b) Address: 1101 Nanticooke Avenue -30

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or crematory: BALTIMORE CEM.
Location: BALTIMORE, MD.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 Date rec'd by registrar: DEC 9 - 1947 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1947, at 11.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1947, to Dec 7 1947, and that I last saw h[illegible] alive on Dec 7 1947.

	Duration
Immediate cause of death: Pulmonary edema	2 hrs
Due to: Hypertensive Cardiov Vascular Disease	2 years
Due to:	
Other Conditions: Bronchial Asthma (include pregnancy within 3 months of death)	?

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: John P. Ulwick Jr
Address: 1227 Wash. Blv'd Date signed: 12/8/47 M D

VS 150

X

G57784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G57784 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2705 Tivoly Ave.
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Tivoly Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK KERNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Fredericka Wahl
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 17 1835

8. AGE: Years	Months	Days	If less than one day
82	4	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Die-maker, retired
11. Industry or business

FATHER
12. Name Michael Kerner
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mrs. Fredericka Kerner
(b) Address 2705 Tivoly Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10. 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

DEC 9 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1947, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1947, to Dec 6 1947, and that I last saw h— alive on Dec 6 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	2 wks.
Due to Arterial Sclerosis	10 yrs
Due to Hypertrophy Prostate	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Finnegan M. D.
Address 2858 Harford Rd. Date signed 12-8-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 657785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 N. Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country none

3 (a) FULL NAME Clifton Matthews

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/1889

8. AGE: Years 58 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Shadyside, MD. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Lewis Matthews
13. Birthplace md

MOTHER 14. Maiden Name Susie Moore
15. Birthplace md

16 (a) Informant Mrs. M. Nelson
(b) Address 1804 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/42 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Mrs. M. Nelson
(b) Address 1303 Presstman St

19 (a) DEC 9 — 1942 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7- 1942, at 4:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1942, to 12-7 1942, and that I last saw him alive on 12/7 1942.

Immediate cause of death Carcinoma of Cardia - Metastatic Renal

Due to disease

Due to Pulmonary Congestion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Garner

Address 1514 Division St Date signed 12/9/42

X

G57786

443893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G57786

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5600 Swift Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Geraldine Sykes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	col.	married

6 (b) Name of husband or wife Jimmie Sykes
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 4-6-11

8. AGE: Years	Months	Days	If less than one day
36	8	1	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation housef.
11. Industry or business

FATHER
12. Name Elizah Miller
13. Birthplace W. Va.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or crematory Montgomery
Location Montgomery Co. W. Va.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1313 Preston St

19 (a) DEC 9- 19[illegible] (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. - 7- 1947 at 4 45- A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5- 1947 to 12-7- 1947. and that I last saw h[illegible] alive on 12-7- 1947.

	Duration
Immediate cause of death (a) Intestinal Hemorrhage	
Due to (b) Ruptured Vessel	1 hour
Due to (c)	
Other Conditions Peritonitis and Diabetic Acidosis (Include pregnancy within 3 months of death)	3 days

Date of operation None
Major findings of operation:
of autopsy: R. Tubo ovarian Abscess. Peritonitis & Gastric Rupture present in Stomach at cardiac end

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. E. Van Metre JR MD M. D.
Address Johns Hopkins Hosp Date signed 12/7/47

118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65'7787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. 65'7787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 S. Fremont Ave
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 S. Fremont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME VERNON M. SMOTHERS

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 216-10-9858

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/23/1914

8. AGE: Years	Months	Days	If less than one day
33	3	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Worker at Sugar Ref.
11. Industry or business Sugar Refinery

FATHER
12. Name Arthur Smothers
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Alverta Bailey
15 Birthplace Balto. Md

16 (a) Informant Mrs. Roxie Howard (Sister
(b) Address 1107 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk
Location Balto. County, Md

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) DEC 9 - 1947 (Accepted by registrar) (b) Huntington Mills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th 1947, at 8:50 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/24 1947 to 12/7 1947, and that I last saw h alive on 12/6 1947.

	Duration
Immediate cause of death Acute.	
Pulmonary Tuberculosis	1 mo.
Due to	
Due to	
Other Conditions Chronic Endocarditis	1 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Travenden M. D.
Address 1112 Sea Date signed 12/9/47

X

G57788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. G57788

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 W. Calvert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia mae Crafford

3 (b) If veteran, name war World War # II

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1924

8. AGE: Years 23 | Months 0 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation waitress

11. Industry or business Arundel Hotel

FATHER
12. Name John J. Crafford
13. Birthplace Virginia

MOTHER
14. Maiden Name Ella Bolton
15. Birthplace N. Carolina

16 (a) Informant John J. Crafford
(b) Address 2034 Glasgow St. Portsmouth, Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Olivet Branch
Location Portsmouth, Virginia

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 DEC 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1947, at 8 35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation, Strangulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/7/47 about 8 A. 11/1 M.
(b) Where did injury occur? 1039 W. Calvert St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas stove Homicide suicide

23. Signature Carl L. Reyer M.D. Medical Examiner
Date signed 12/7/47

X 128

65'7789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93E

Registered No. 65'7789

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Liberty Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME G. Hollins Stierhoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Grace L. Stierhoff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1888

8. AGE: Years	Months	Days	If less than one day
59 60	7	28	hr. min.

9. Birthplace Pikesville, Maryland
(Town, county, and state)

10. Usual Occupation Retired Master Plumber

11. Industry or business

FATHER
12. Name George H Stierhoff
13. Birthplace Pikesville, Md.

MOTHER
14. Maiden Name Florence E. Bunn
15. Birthplace Maryland

16 (a) Informant Mrs. Grace L. Stierhoff
(b) Address Liberty Road, Randallstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Miller Funeral
(b) Address 4510 Liberty Heights Ave.

19 (a) Dec 9 1947 (b) Huntington Williams, M.D.
(Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1947, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1947, to Dec. 8 1947, and that I last saw him alive on Dec. 8 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Embolism	
Due to	
Other Conditions Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Bullock
Address 4 E. Lexington St. Date signed 12/9/47

VS 190

83 B

G57790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57790

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hospital 8-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Dillman (Joseph M.Dillman)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-01-9335

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Edna C.Shea

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) July 22, 1902

8. AGE: Years 45 | Months 4 | Days 9 | If less than one day ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Shipping clerk

11. Industry or business Candy Mfrs.

FATHER
12. Name Jacob M.Dillman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary M.Dwyer
15. Birthplace Balto. Md.

16 (a) Informant Mrs.Dorothy C.Cook (Daughter)
(b) Address 1517 E.Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd, Balto: Md.

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) DEC 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Dec 1947 at 1[illegible] P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Dec 1947 to 8 Dec 1947, and that I last saw him alive on 8 Dec 1947

Immediate cause of death: Cardiac asthma — Duration:

Due to: Arteriosclerotic heart disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham, M.D.
Address Franklin Sq Hosp Date signed 8 Dec '47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register 657791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Woodyears St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Credit Scott

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/5/1863

8. AGE: Years 84 | Months 7 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Kewbern N.C (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name — Daniels
13. Birthplace — N.C

MOTHER
14. Maiden Name — unknown
15. Birthplace — N.C

16 (a) Informant Roberta Thaxton
(b) Address 820 Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/97 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location West Pant Datto Md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 922 N. Mount St.

19 DEC 9 - 1897 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1897, at 3:25A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1897 to 12/7 1897, and that I last saw her alive on 12/7 1897.

Immediate cause of death Myocardial Insufficiency — Duration
Due to Generalized Arteriosclerosis
Due to Gangrene of entire left leg
Other Conditions Pulmonary edema & congestion, Fibromyoma Uteri
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: On Arteriosclerosis, Gangrene and

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marcus W. Moore
Address Provident Hospital Date signed 12/9/97 (M) (D)

98

G57792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57792

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5201 Eugene Avenue
(c) Hospital or institution: 27-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5201 Eugene Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Loretta Prosser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Paul John Prosser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1893

8. AGE: Years	Months	Days	If less than one day
54	9	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Thomas Ross
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Paul John Prosser
(b) Address 5201 Eugene Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) DEC 3 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Nov. 1947 to 7 Dec 1947, and that I last saw her alive on 6 Dec 1947

Immediate cause of death	Duration
Hypertensive Cardiovascular Disease - Severe	10 yrs +
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Trabert Jr. M. D.
Address 20 E Preston St Balt. 2 Date signed 8 Dec '47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57793

LW 115730

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G57793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 172
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 W Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry, W. Brown, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29- 1907

8. AGE: Years 40 | Months 2 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Brown
13. Birthplace ?

MOTHER
14. Maiden Name Martha Satterfield
15. Birthplace ?

16 (a) Informant B.C.H.Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Halethorpe, Md.

18 (a) Funeral director George J. Gibbons Sr.
(b) Address 1725 Druid Hill Ave.

19 (a) DEC 9 1947 (Date) by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8-47 19... at 6:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1947 to 12-8- 1947, and that I last saw h. in alive on 12-8 1947

Immediate cause of death Pulmonary Tuberculosis — Duration 1½ years

Due to

Due to

Other Conditions Hypertensive Cardiovascular Disease — 1½ yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 12-8-47

VS 150

Q57794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. Q57794

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 E. Cross St.
(c) Hospital or institution: none 24-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 E. Cross St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Wunder

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Andrew Wunder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1882

8. AGE: Years	Months	Days	If less than one day
65	2	14	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Valentine Hartman
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Hartman
15. Birthplace

16 (a) Informant Rev. G. Ernest Wunder
(b) Address Shenandoah Junction, W. Va.

17 (a) Burial (b) Date thereof 12/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director John C. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) DEC 9 1947 Huntington Williams, M.D.
(Date received by reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1947, at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1947 to Dec 8 1947, and that I last saw h[illegible] alive on Dec 8 1947

Immediate cause of death	Duration
Diabetes Mellitus	
Due to	
Due to	
Other Conditions Ulcers, foot (R.). Arteriosclerosis, Hypertension	

(Underline pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature Justus C. Schwenzfeier
Address 1337 S. Charles St. Date signed 12/9/47

VS 130

057795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

Registered No. 057795

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ——
(c) City or town Baltimore (17)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2873 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME NIRMAN EDWARD HORN

3 (b) If veteran, name war ——
3 (c) Social Security Account No. 705-45-0179

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Jno. N.E. Horn
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec 6, 1888

8. AGE: Years	Months	Days	If less than one day
59	0	3	—hr. —min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Draftsman
11. Industry or business

FATHER
12. Name William Frederick Horn
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Florence George
15. Birthplace England

16 (a) Informant wife
(b) Address 2873 Woodbrook Ave, Balto-17

17 (a) Burial (b) Date thereof 12/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore, Md.

18 (a) Funeral director Wilhelm & Son Inc.
(b) Address 1219 E. Fayette St.

DEC 10 1947 Washington Hollinger Jr. Registrar
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1947 at 7:04 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1947 to Dec 9 1947 and that I last saw him alive on Dec. 8 1947.

Immediate cause of death Shock — Duration 24 hrs

Due to Operation (Gastro-oesophageal anastomosis) — Duration 3 mos

Due to Granuloma oesophagus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 5, 1947

Major findings of operation: Granuloma

of autopsy: "

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno. W.C. Finney M. D.
Address Union Memorial Hosp. Date signed 12-9-47

X

G57796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57796

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 E. Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town 518 E Spaman Pl. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clifton Jackson

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sallie M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1/1875

8. AGE: Years 72 | Months 0 | Days 7 | If less than one day ___ hr. ___ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Auto Mechanic

11. Industry or business Bethlehem Steel

FATHER
12. Name Peter Jackson
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Raymond M. Jackson
(b) Address 7961 Dunmary Rd Dundalk

17 (a) Friday (Burial, cremation, or removal) (b) Date thereof 12/12/1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Md

18 (a) Funeral director William Cook Inc
(b) Address 1717 St Paul St.

19 (a) DEC 10 1947 (Date rec'd by registrar) (b) Function for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1947, to Dec 9 1947, and that I last saw him alive on 12-9 1947.

	Duration
Immediate cause of death Myocardial Infarction	
Due to Arteriosclerosis & Myocardial Insufficiency	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. Edward Nachlas M. D.
Address Sinai Hospital Date signed 12-9-47

G57797 Schreiber Fulton-Lombard 275 G 3740 G57797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Hollins st
(c) Hospital or institution: V 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Hollins st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Conway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, ~~married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Peter Conway

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1st 1861

8. AGE: Years 86 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name August Reinhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth (Unknown)
15. Birthplace Germany

16 (a) Informant John A. Bayer
(b) Address 1807 Hollins St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 10 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1947, at 7a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1942 to Dec 8 1947.
and that I last saw ~~her~~ alive on Dec 7 1947.

	Duration
Immediate cause of death Arteriosclerotic myocarditis	7
Due to Generalized Arteriosclerosis	?
Due to age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Schreiber M. D.
Address 541 Fulton Ave Date signed 12-9-47

VS 150 2 12 13

X

G57798 Dr Geo Trautmann rural 2852 Harford Rd G57798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57798

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd
(c) Hospital or institution: 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 147 N. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Della T. Hampton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Klyde S. [illegible] T. Hampton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 22nd 1867

8. AGE: Years: 80 | Months: 9 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Harford Co. Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Own Home

FATHER 12. Name: Goldsmith Thompson
13. Birthplace: Md.

MOTHER 14. Maiden Name: Elizabeth (Unknown)
15. Birthplace: Md.

16 (a) Informant: Leonard F. Hampton
(b) Address: 152 N. East Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Abington M.E.
Location: Harford Co. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) DEC 10 1947 (Date rec'd by registrar) (b) Waiting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8th 1947 at 5 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1947 to Dec 8 1947 and that I last saw her alive on Dec 7 1947.

	Duration
Immediate cause of death: Acute cardiac Dilatation	2 wks
Due to: Pulmonary Oedema	2 days
Due to: Arteriosclerosis	10 yrs
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Geo. L. Trautmann M. D.
Address 9858 Harford Rd. Date signed 12-9-47

G57799 Kleiman 2803 Edmondson Ave

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered No. G57799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2874 W. Lanvale St
(c) Hospital or institution: 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2874 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Elizabeth Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband Joseph Richard Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1874

8. AGE: Years: 68 | Months: 3 | Days: 23 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Christopher Buckman
13. Birthplace Hampstead Md.

MOTHER
14. Maiden Name Barbara Elizabeth Dietzman
15. Birthplace Hampstead Md.

16 (a) Informant Joseph R. Davis Jr.
(b) Address 606 N. Dukeland St

17 (a) Burial (b) Date thereof 12/11/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 10 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8th 1947, at 4:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1940 to Dec 8 1947, and that I last saw her alive on Dec 8 1947.

	Duration
Immediate cause of death: Hypertensive Cardio-Vascular Renal Disease	9 years.
Due to: Chronic Glomerular Nephritis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herman R Kleiman M.D.
Address 3803 Edmondson Ave Date signed 12/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G57800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G57800

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Union 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4229 Pimlico Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Jessie Schuchman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac Lab
13. Birthplace Poland

MOTHER
14. Maiden Name Hannah
15. Birthplace Poland

16 (a) Informant Joseph Schuchman
(b) Address 4229 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eastern Place

DEC 10 1947 (Local registrar) per Curtis Taylor Williams (Registrar)

VS 150 AAIA

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1947, at 2.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Dec 1947, and that I last saw h.. alive on Dec 9 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	5 yrs.
Due to	
Other Conditions Cardiovascular Renal Disease.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rev Dr. Kolman Wolf
Address 3700 Park Heights Ave Date signed 12/9/47 M. D.

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657801 Bc • L-95860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

657801 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bryan and Dukeland Sts
(c) Hospital or institution:
West Balt. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 12½ hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balt. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7613 Cypress Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Ann Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/9/47

8. AGE: Years | Months | Days | If less than one day: 12 hr. 47 min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stanley Bernard Gardner
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Alberta B. Plank
15. Birthplace Durham, N.C.

16 (a) Informant Alberta Gardner
(b) Address 7613 Cypress Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 8, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 10 1947 Registrar Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/47 19 at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3/47 19 to 12/4/47 19, and that I last saw her alive on 12/4/47 19

Immediate cause of death Pneumothorax
Spontaneous

Due to Pneumothorax

Due to Pneumothorax spontaneous

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: atelectasis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G.S. Waldrop

Address WBCH Date signed 12/5/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G57802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5113 Herring Run Drive
(c) Hospital or institution: 27-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5113 Herring Run Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Dugitt Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	widower

6 (b) Name of husband or wife Lotta Carrie G. Dugitt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1870

8. AGE: Years	Months	Days	If less than one day
77	5	8	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Retired B. & O. R.R.
11. Industry or business Locomotive Fireman

FATHER
12. Name John T. Dugitt
13. Birthplace Va.

MOTHER
14. Maiden Name Carper
15. Birthplace Va.

16 (a) Informant L. Earle Dugitt
(b) Address 732 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson + Longwood St.

18 (a) Funeral director Harry H. Little
(b) Address 4101 Edmondson Ave

19 DEC 10 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7/47. 19 at 5:18 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/13 19 46 to 12/7/47 19 47.
and that I last saw h[illegible] alive on 12/7 19 47.
Immediate cause of death Uremia
C.V.D. - Hypertension

Duration
2 years

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Victor F. Armstrong M. D.
Address 1016 S. Ellwood Ave Date signed 12/9/47

657803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

657803 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Woodington Rd.
(c) Hospital or institution: 168
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Woodington Rd. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara P. Heilman

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FM	W	Widowed

6 (b) Name of husband or wife Philip A. Heilman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1878

8. AGE: Years	Months	Days	If less than one day
69	9	26	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Martin L. Wildermuth
13. Birthplace Ohio

MOTHER
14. Maiden Name Katie Koebel
15. Birthplace Ohio

16 (a) Informant Mr. Clinton V. Lakin
(b) Address Belfonton Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave,

19 DEC 10 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1947, at 1130 M P

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 19 to 12/7/47 19, and that I last saw h. alive on 12/7/47 19

Immediate cause of death Myocarditis
Due to Arteriosclerosis
Due to Chronic Interstitial Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
4 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter F. Thomson M. D.
Address 4015 Edmondson Ave Date signed 12/9/47

X

G57804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G57804

Registered No.

TN. 114676

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~xxx~~ 1-mo. 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Stevenson Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Hattie Branch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Sept.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17th. 1898

8. AGE: Years 49 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace N. C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hilroy Deloatch
13. Birthplace N. C

MOTHER
14. Maiden Name Penie Watson
15. Birthplace N. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Leroy D. Wilson
(b) Address 1000 Brantly Ave

19 (a) DEC 10 1947 (Date rec'd by registrar) (b) Registrar Williams M

VS 150

MEDICAL CERTIFICATION A. M

20. DATE OF DEATH December 8th 1947, at 8.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22nd 1947 to Dec. 8th 1947, and that I last saw her alive on Dec. 8th 1947

Immediate cause of death	Duration
Uremia	
Due to Nephritis.	
Due to	
Other Conditions Hypertensive Cardiovascular Disease.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Bamford
Address Balt. City Hosp. Date signed 12-9-47 M

X

G57805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G57805
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 826 N. Bond St.
(c) Hospital or institution: 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IVY LEONARD KEENE

3 (b) If veteran, name war
3 (c) Social Security Account No. 216-10-3877

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C.	MARRIED

6 (b) Name of husband or wife BIRDIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-9-1898

8. AGE: Years	Months	Days	If less than one day
49	8	28	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation SKILLED Laborer
11. Industry or business BETHLEHEM STEEL

FATHER
12. Name WM. I. KEENE
13. Birthplace Md.

MOTHER
14. Maiden Name IRENE ENNALS
15. Birthplace Md

16 (a) Informant BIRDIE KEENE
(b) Address 826 N. Bond St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-10-47 (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location A.A. COUNTY, Md

18 (a) Funeral director Joseph H. Locke, Jr.
(b) Address 1304 N. CENTRAL Av

19 DEC 10 1947 (Signature of local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7 1947 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Dec 7 1947 and that I last saw him alive on Dec 7 1947

Immediate cause of death Chronic Nephritis
Due to Glomerulo-Nephritis
Due to

Duration
1 Mo.

Other Conditions Mitral Insufficiency and Systolic Murmur
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young M. D.
Address 1129 E. Monument Date signed 12/9/47

G57808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57808

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 E. Fayette St
(c) Hospital or institution: 6-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 E. Fayette St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME VICTOR - KAZMIERSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-6885

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Mar. 6-1896

8. AGE: Years 51 | Months 9 | Days 2 | If less than one day ....hr. ....min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Molofsky & Sons

FATHER
12. Name Michael Kazmierski
13. Birthplace Poland

MOTHER
14. Maiden Name Marcella Binkowski
15. Birthplace Poland

16 (a) Informant Frances Kazmierski
(b) Address 2109 E Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) DEC 10 1947 (Date received by registrar) (b) Huntington Williams Mort

V S 150 ...IAIA

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8 1947 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1947 to Dec. 8 1947 and that I last saw h.i.m alive on 12/8 1947

Immediate cause of death Coronary Thrombosis — Duration 5 Hr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. John F. Hawkins M. D.

Address 1016 S. Eutaw Date signed 12/9/47

G57807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √112

G57807 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3806 Pleasant Place.
(c) Hospital or institution: 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Pleasant Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH GAVIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1932

8. AGE: Years	Months	Days	If less than one day
15	7	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Joseph M. Gavin, Jr.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Charlotte M. Weitzel.
15. Birthplace Maryland.

16 (a) Informant Joseph M. Gavin, Jr.
(b) Address 3806 Pleasant Place.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Dec 11/47 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City, Md.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615 17 Chestnut Ave.

19 (a) DEC 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at 8.15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asthma, Bronchial Emphysema
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 12-9-47

X

G57808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57808
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 N. Kenwood Ave.
(c) Hospital or institution: 9.3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 N. Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANNA W. GOETTE

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles Karl Goette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1859

8. AGE: Years	Months	Days	If less than one day
88	0	3	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Karl Newbuer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Anna Wagner
(b) Address 1114 N. Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery or crematory Trinity Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 10 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Dec 8 1947 and that I last saw h alive on Dec 7 1947

Immediate cause of death		Duration
	Hypertension	
Due to	Carditis	two
Due to	Bronchopneumonia	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address 600 [illegible] Date signed Dec 9 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57809 BALTIMORE CITY HEALTH DEPARTMENT G52800
CERTIFICATE OF DEATH √94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 20-T
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3518 Caton ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILBUR CARLYLE EDGAR

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Lillian L. Edgar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1894

8. AGE: Years	Months	Days	If less than one day
53	1	21	hr. min.

9. Birthplace: Cambridge, Md. (Town, county, and state)
10. Usual Occupation: Salesman
11. Industry or business: Bread Co.

FATHER
12. Name: William C. Edgar
13. Birthplace: Bishopshead, Md.

MOTHER
14. Maiden Name: Mamie Rea
15. Birthplace: Cambridge, Md.

16 (a) Informant: Mrs. Lillian Edgar
(b) Address: 3518 Caton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 10 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1947 at 2.25 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 12-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57810
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1904 Cedric Rd.
(c) Hospital or institution: 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 Cedric Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HERBERT HOLLINGER HARTMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Harriett Freeman Hartman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 10, 1878

8. AGE: Years	Months	Days	If less than one day
69	8	29	hr. min.

9. Birthplace Chambersburg, Pa.
(Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business Retired

FATHER
12. Name Aaron Stewart Hartman
13. Birthplace Pa.

MOTHER
14. Maiden Name Julia C. Hollinger
15. Birthplace Pa.

16 (a) Informant Mr. Herbert H. Hartman, Jr.
(b) Address 3404 W. North Ave.

17 (a) Removal (b) Date thereof 12/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Grove Cem.
Location Chambersburg, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 10 1947 (b) Huntington Williams M.D.
(Accepted by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1947, at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5 1947 to 12-9 1947 that I last saw him alive on 12-9 1947.

Immediate cause of death Cerebral Apoplexy (Stroke) — Duration 1 day
Due to Hypertensive Cardio Vascular Disease — 5 yrs.
Due to with Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evelyn E. Little M. D.
Address 10 W. Madison St. Date signed 12-9-47

X

657811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 43a

Registered No. 657811

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Edgewood Nursing Home 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE J. CUPIT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Herbert C. Cupit
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1868

8. AGE: Years 79 | Months 8 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Cleveland, Ohio (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edwin Parsons
13. Birthplace England

MOTHER
14. Maiden Name Emily O. Ranney
15. Birthplace England

16 (a) Informant Mr. John R. Cupit
(b) Address 3700 N. Charles St. (Northway Apts.)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 10 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947 at 9:45a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to 12-8 1947 and that I last saw her alive on 12-8 1947

Immediate cause of death: Cerebral Haemorrhage — Duration: 4 Dys.
Due to: Senility
Due to: Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. L. Ewart Jr. M. D.
Address 36 York Court Date signed 12-9-47

X

G57812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G57812 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3121 O'Donnell St.
(c) Hospital or institution: 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LAURA VIRGINIA McABEE

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: William Edwin McAbee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 31, 1868

8. AGE: Years 79 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles O. Conley
13. Birthplace Baltimore Co.

MOTHER
14. Maiden Name Martha Moran
15. Birthplace Unknown

16 (a) Informant Mrs. Howard O. McAbee
(b) Address Round Bay

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 10 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 19 47, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7/47 19 to 12/8/47 19 47, and that I last saw her alive on 12/7/47 19

Immediate cause of death: Coronary occlusion — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. Hundrooms M. D.
Address 1016 S. Exeter Ave Date signed 12/10/47

G57813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57813

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3131 O'Donnell St.
(c) Hospital or institution: 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3131 O'Donnell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS DAVID JOHNS

3 (b) If veteran, name war: -

3 (c) Social Security Account No. 216-03-3873

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Louise Johns (nee Zimmerman) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1888

8. AGE: Years	Months	Days	If less than one day
59	5	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Revere Copper & Brass, Inc

FATHER
12. Name Thomas Johns
13. Birthplace Wales

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Philadelphia, Pa.

16 (a) Informant Mrs. Mary Johns
(b) Address 3131 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 10 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 8 1947 and that I last saw him alive on Dec 8 1947.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease	
Myocardial Failure	12-1-47
Due to acute coronary occlusion	12-8-47
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ed Schmunk M. D.
Address 842 S. Ext Ave Date signed 12-10-47

G57814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G57814

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 29 E. 21st St.
(c) Hospital or institution: 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 E. 21st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK N. H. LANG

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ada Smith Lang
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1870

8. AGE: Years	Months	Days	If less than one day
77	6	10	hr. min.

9. Birthplace Wilmington, Del.
(Town, county, and state)
10. Usual Occupation Owner Printing Business
11. Industry or business Retired

FATHER
12. Name James N. Lang
13. Birthplace Wilmington, Del.

MOTHER
14. Maiden Name Catherine E. Howe
15. Birthplace Ireland

16 (a) Informant Mr. Donald Lang
(b) Address 3306 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 10 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at 7:15a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1947 to Dec 7 1947, and that I last saw him alive on Dec 7 1947.

	Duration
Immediate cause of death Myocardial Failure	1 month
Due to Arteriosclerosis, senile, Coronary and	3-4 years
Due to generalized	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Peace M. D.
Address 2105 N Charles St Date signed Dec 9, 1947

VS 150

G57815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G57815

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 133 Willard St
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 Willard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto Strossner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna L. Strossner
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Sept 29th 1866

8. AGE: Years 81 | Months 9 2 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name —
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Toffer
15. Birthplace Germany

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 11 47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director A. Jones
(b) Address 501 Old Wood PK Way

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 8 1947, at 3:00 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Gelbach M.D.
Medical Examiner.
Date signed Dec 8, 1947

(57816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registration No. 57816

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2222 E Hoffman Ave
(c) Hospital or institution: 8-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 E Hoffman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James N. Speight Sr

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha R Speight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31 1899

8. AGE: Years	Months	Days	If less than one day
68	6	6	hr. min.

9. Birthplace Deep Creek Va (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Arundel Corp.

FATHER
12. Name Hargy Speight
13. Birthplace Deep Creek Va

MOTHER
14. Maiden Name Mary (unknown)
15. Birthplace Deep Creek Va

16 (a) Informant James N Speight Sr
(b) Address 1609 N Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/47 (month) (day) (year)
(c) Cemetery or crematory Dove Brooke
Location Fortamouth Va

18 (a) Funeral director Williams & Son
(b) Address 1214 E Pratt St

19 DEC 10 1947 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

V S 150 Go be approved Expenses U.S. per Earl Rogers

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1947, at 6 30p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1947 to Dec 7 1947, and that I last saw h[illegible] alive on Dec 7 1947.

Immediate cause of death	Duration
Coronary Occlusion	20 min
Due to Aortic Stenosis	30 min
Hypertension	20 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature 2815 Hatton Rd M. D.
Address Date signed 12/8/47

C57817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

C57817

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Eutaw Place & Lake Drive.

(b) Street address Esplanade Apts.

(c) Hospital or institution: 13-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Esplanade Apts. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME TILLIE BENESCH.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Albert Benesch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1881.

8. AGE: Years	Months	Days	If less than one day
66	5	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph Agular,

13. Birthplace Germany.

MOTHER 14. Maiden Name Amelia Birnbaum,

15. Birthplace Germany.

16 (a) Informant Mrs. Dewey Farbman,

(b) Address 2425 Lakeview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/47. (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location Balto. Md.

18 (a) Funeral director Harris Mortuary Chapel

(b) Address 1902 Eutaw Place.

19 (a) DEC 10 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9th. 1947 at 1.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Dec 9 1947, and that I last saw her alive on Dec 9 1947.

Immediate cause of death	Duration
Acute Dilatation of heart	2 hrs
Due to Chronic nephritis	3 yrs
Due to Diabetes	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Frederick Lentz M. D.

Address Temple Garden Apts Date signed 12-9-47

VS 150

057818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

057818

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eutaw Place & Lake Drive. Esplanade Apts.

(c) Hospital or institution: 131

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Esplanade Apts. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME HENNIE VAN LEER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 13, 1862

8. AGE: Years	Months	Days	If less than one day
85	8	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Solomon VanLeer,

13. Birthplace Holland.

MOTHER

14. Maiden Name Hannah Hirsch,

15. Birthplace Germany.

16 (a) Informant Mr. Charles B. Stephany,

(b) Address Cordova Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.11.47. (month) (day) (year)

(c) Cemetery or crematory Oheb Shalom Cem.

Location Balto. Md.

18 (a) Funeral director Harris Levin Strauss & Son

(b) Address 1902 Eutaw Place

19 DEC 10 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9th. 1947; at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1947 to Dec 9 1947 and that I last saw h[illegible] alive on Dec 9 1947

	Duration
Immediate cause of death: Cardiac failure	6 mos
Due to: arterio-sclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature I. Frederick Lantz M.D.

Address Temple Garden Apts. Date signed 12/9/47

G57819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57819

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 18.3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 S. Stockton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM FOSTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Martha Foster.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1878

8. AGE: Years	Months	Days	If less than one day
69	3	1	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Dennett Foster
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Foster
15. Birthplace Md.

16 (a) Informant Martha Foster
(b) Address 13 S. Stockton St.

17 (a) Burial (b) Date thereof Dec. 10, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Wm. Foster Williams
(b) Address 322 W. Lexington St.

19 (a) DEC 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1947, at 11 p.M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner
Date signed 12-6-47

657820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 657820

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 316 FORREST ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 Forrest St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY FOREY (FOY)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE | 5. Color or race COLORED | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-1881

8. AGE: Years 66 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation DOMESTIC

11. Industry or business

FATHER 12. Name JACOB CASEY
13. Birthplace MARYLAND

MOTHER 14. Maiden Name KNOWN
15. Birthplace UNKNOWN

16 (a) Informant CIARA HOOD
(b) Address 12 N. N ST. N.W. WASH.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore Maryland

18 (a) Funeral director Wilbain A. Jackson
(b) Address 916 Penna. Ave

19 DEC 10 1947 (Date filed by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1947, at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947, to Dec 1947, and that I last saw h[illegible] alive on Dec 6 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertension	6 months
Due to Cardiovascular disease	6 months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. E. Burnett M. D.
Address 131 Eastern Ave. Date signed 12-10-47

G57821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G57821 Registered No. 1314

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 S. Fremont Ave.
(c) Hospital or institution: 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S. Fremont Ave (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony P. Anskaitis

3 (b) If veteran, name war: none.

3 (c) Social Security Account No. ✓

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name ~~of husband~~ or wife: Mary M.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov 21 - 1886

8. AGE: Years 61 | Months - | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace: Lithuania (Town, county, and state)

10. Usual Occupation: Tailor.

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Mary M. Anskaitis
(b) Address: 313 S. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park.
Location: Frederick Road.

18 (a) Funeral director: Charles W. Fackenthal
(b) Address: 703 McHenry St.

19 (a) ____ (b) ____ (Date received by registrar) Huntington Williams, M.D. Registrar

DEC 10 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Dec 1947, at 4:35 M

21. I certify that death occurred on the date above stated, that I attended deceased from 16 Aug 1947 to 8 Dec 1947 and that I last saw him alive on 8 Dec 1947

	Duration
Immediate cause of death: Cardio-Vascular Renal Disease	
Due to: Arteriosclerosis	4 yrs
Due to:	
Other Conditions: Bronchial Asthma	1 yr

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Edward J. Nilon M.D.
Address: 682 Wyoming Ave Date signed: 10 Dec 47
Baltimore-30

G57822

G57822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga D.O.A.
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 W. 25th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Astovit

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Grace M. Woodall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 31st 1898

8. AGE: Years	Months	Days	If less than one day
48	11	9	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business Railway Express

FATHER
12. Name Paul Astovit
13. Birthplace Hungary

MOTHER
14. Maiden Name Mary Tallion
15. Birthplace Hungary

16 (a) Informant Mrs Grace M. Astovit
(b) Address 2637 Lanvale Ave

17 (a) Burial (b) Date thereof 12/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2930 Frederick Ave.

18 (a) Funeral director John J. Cannon & Son
(b) Address 901-03 Hollins St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

DEC 10 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9 1947, at 6:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h/s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/10/47

G57823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G57823 Registered No. 130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1813 E. Baltimore St.
(c) Hospital or institution: 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John Ranzino

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife: ~~XXXXXX~~ late Marietta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 13 1854

8. AGE: Years	Months	Days	If less than one day
93	10	25	hr. min.

9. Birthplace Cefalu Palermo Italy (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Giuseppe Ranzino
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Di Naso
15. Birthplace Italy

16 (a) Informant Pete Ranzino (Son)
(b) Address 1407 Fort Rd. Middle River Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 11 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Balt. Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52[illegible] Washington Blvd. Halliams, Md.

DEC 10 1947

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7- 1947, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3- 1947 to 12-7 1947 and that I last saw him alive on 12-7 1947

Immediate cause of death Hyp. Static Pneumonia. — Duration 2 Days

Due to old age + acute nephritis-

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. D'Amico M.D.
Address Medical arts Bldg Date signed 12-8-47

VS 150

G57824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57824 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 Ellamont St.
(c) Hospital or institution: 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Ellamont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE BACKER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: -
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 6, 1857
8. AGE: Years 90 | Months 9 | Days 2 | If less than one day hr. min.
9. Birthplace Carroll Co., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Backer
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Stephens
15. Birthplace Germany

16 (a) Informant Miss Mary E. Backer
(b) Address 2004 Edgewood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel Cem.
Location Freedom, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

DEC 10 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at 3:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1947 to Dec 8 1947, and that I last saw h[illegible] alive on Dec 8 1947.

Immediate cause of death	Duration
Chronic cardiac dis.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest W. Palmer M. D.
Address 1730 Park Ave Date signed 12/9/47

X

G57825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57825 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2950 Arunah Ave.
(c) Hospital or institution: 166
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2950 Arunah Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** LOUIS SMITH, Sr.

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 218-03-7780

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Lydia Smith, (nee Knapp)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1871

8. AGE: Years 76 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Barber - retired
11. Industry or business

FATHER
12. Name John Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Hellena Miller
15. Birthplace Germany

16 (a) Informant Mrs. Lydia Smith - wife
(b) Address 2950 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received) (Local registrar) Huntington Williams, M.D.
Dec 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at 5.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947 to Dec 8 1947. and that I last saw h.im alive on Dec 8 1947

Immediate cause of death: Coronary Thrombosis
Arterio Sclerotic type
Heart disease with
Congestive failure
Due to Generalized arterio sclerosis - Hypertension

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 2 hours. Chronic Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Michel M. D.
Address 701 Edmondson Ave Date signed Dec 9 1947

X

G57826 BALTIMORE CITY HEALTH DEPARTMENT G57826
Registered No.

CERTIFICATE OF DEATH 512

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Eight St.
(c) Hospital or institution: S. Balti Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 34 Admiral Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Otto Schmiedicke Otto Schmiedicke

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-5004

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Whi	Married

6 (b) Name of husband or wife Henriette Schmiedicke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1878

8. AGE: Years	Months	Days	If less than one day
69	3	16	17 hr. min.

9. Birthplace Berlin, Germany
(Town, county, and state)

10. Usual Occupation Machinist
11. Industry or business Fisher Brush Machine Co.

FATHER
12. Name Paul Schmiedicke
13. Birthplace Germany

MOTHER
14. Maiden Name Martha
15. Birthplace Germany

16 (a) Informant Mrs. Henrietta Schmiedicke
(b) Address 34 Admiral Blvd., Dundalk

17 (a) Burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9 1947, at 4 1/2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1947 to 12/9 1947 and that I last saw h[illegible] alive on 12/9 1947.

Immediate cause of death Bronchopneumonia

Duration 2 da

Due to Carcinoma of prostate

Due to

Other Conditions Local metastasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation Carcinoma of prostate

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Cooper M. D.
Address S. B. G. Hosp. Date signed 12/9/47

VS 150

G57827 BALTIMORE CITY HEALTH DEPARTMENT G57827
CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 39

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22. W. Elm Avenue (If rural give location)
(e) Citizen of foreign country? ~~Yes~~ No (Yes or No) If yes, name country

3 (a) FULL NAME Theresa Constance Bruno Mrs

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Nicholas G.
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 10/15/08

8. AGE: Years 39 | Months 1 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Stanley Bugno
13. Birthplace Austria

MOTHER 14. Maiden Name Frances ?
15. Birthplace Poland

16 (a) Informant Nicholas G Bruno
(b) Address 22 W. Elm Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12 12 47 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR RD

18 (a) Funeral director MARTIN W. EDIPPEL SONS
(b) Address 2410 BELAIR RD

19 (a) ____ (b) ____ (Date received by registrar) Registrar

DEC 10 1947 Washington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8/47 19____, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/47 19____ to 12/8/47 19____, and that I last saw h~~e~~ alive on 12/8/47 19____

Immediate cause of death	Duration
Respiratory failure	
Due to Tuberculosis pulmonary - advanced	
Due to bilateral	
Other Conditions TBC left Tibia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Attilia A Bailey MD
Address 1400 Caroline Date signed 12/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G57828 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5527 Belair Road
(c) Hospital or institution: 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5527 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Joseph Bauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Catherine M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1881

8. AGE: Years	Months	Days	If less than one day
66	4	2	hr. min.

9. Birthplace Baltimoe, Maryland
(Town, county, and state)
10. Usual Occupation Maryland Steel Products
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Catherine M. Bauer
(b) Address 5527 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-47 (month) (day) (year)
(c) Cemetery or crematory Jeruselem Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) DEC 10 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9th, 1947 at 2:5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1947 to Dec 9 1947, and that I last saw h[illegible] alive on Oct 9 1947.

Immediate cause of death
Bronchial Pneumonia — Duration 2d
Uraemia — 5d
Due to Chronic Interstitial Nephritis — 3mo
Due to Hypertension — 3mo
Due to [illegible] — 3mo
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. F. A. Stevens M. D.
Address 2818 Harford Rd Date signed 12-9-47

X

Dr. Gobley G57829

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G57829 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3109 Northway Drive
(c) Hospital or institution: 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3109 Northway Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emory E. Harshman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Catherine E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1890

8. AGE: Years	Months	Days	If less than one day
57	10	19	hr. min.

9. Birthplace Frederick, Maryland
(Town, county, and state)
10. Usual Occupation Supt. Muhly Bakery
11. Industry or business

FATHER
12. Name Emory E. Harshman
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Catherine Harshman
(b) Address 3109 Northway Drive, 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) DEC 10 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to Dec 10 1947 and that I last saw her alive on Dec 1 1947

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clyde L. Gobley M. D.
Address 5703 Harford Rd Date signed 12 [illegible] 47

G57830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G57830 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Carswell Rd. (W) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary E. Krapp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles Krapp
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1871

8. AGE: Years	Months	Days	If less than one day
76	9	25	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. Haskell
13. Birthplace Maryland

MOTHER
14. Maiden Name Helena Chiles
15. Birthplace Maryland

16 (a) Informant Mr. Charles Krapp
(b) Address 1618 Carswell Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto

18 (a) Funeral director L. D. Luck
(b) Address 5305 Harford Rd.

19 (a) Wm. Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1947, at 1:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1947 to Dec. 9 1947, and that I last saw him alive on Dec. 9 1947.

Immediate cause of death	Duration
Terminal hypostatic bronchopneumonia	6-7 days
Due to Arteriosclerotic Cardiovascular disease	
Due to Chronic lymphocytic Leukemia	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: were performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hubert A. Lewicka
Address St. Agnes Hosp. Date signed 12/9/47 M D

VS 190

G57832 #15 — Found #15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G57832

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH: Found
(a) Baltimore City, Maryland
(b) Street address 1029 E Baltimore St
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: ?? Warden
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unidentified White male

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 55-? Months Days If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY DEC 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 10 1947 (Date rec'd by registrar) (b) Thurlington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1947, at 1 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/20/47 at 9:30 A.M.
(b) Where did injury occur? 1029 E. Baltimore St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Illuminating gas

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 11/20/47

G57833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G57833

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: DOA
(a) Baltimore City, Maryland
(b) Street address 3002 E. Balto St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 E. Balto St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Robert E. Cadden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20 1894

8. AGE: Years	Months	Days	If less than one day
53	9	20	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Police officer

11. Industry or business

FATHER
12. Name Thomas M. Cadden
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary C. Riley
15. Birthplace Md

16 (a) Informant James Cadden
(b) Address 3002 E Baltimore St

17 (a) Burial (b) Date thereof 12/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Cathedral
Location Old Frederick Road

18 (a) Funeral director John C. Moran
(b) Address 3000 E Baltimore St

19 DEC 11 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9 1947 at 12:45 P.M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Inspection find that said deceased came to his death on the day stated above.
(Autopsy or Inquiry) (Autopsy or Inquiry)

Immediate cause of death Coronary Disease — Duration 2 hrs

Due to:

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. H. Lubrecht M.D.
Medical Examiner.
Date signed 12/9/47

VS 6

G57834

G57834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John, 17
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d
(e) Length of stay in Baltimore (yrs., mos., or days) ? Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 St. Paul St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ada — Foot

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1875

8. AGE: Years	Months	Days	If less than one day
72	4	8	hr. min.

9. Birthplace Nova Scotia, [redacted]
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Foot
13. Birthplace England

MOTHER
14. Maiden Name Agnes Mc Culley
15. Birthplace Canada

16. (a) Informant Deceased
(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/47 (month) (day) (year)
(c) Cemetery or crematory Londonderry
Location Baltimore Md

18 (a) Funeral director Fullerton & Ford
(b) Address 1 W. Mt. Vernon Place, Baltimore, Md.

19 (a) (Date rec'd by registrar) DEC 11 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1947 at 4 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1947 to Dec 10 1947 and that I last saw her alive on Dec 10 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Cardiac Decompensation	
Due to Arteriosclerotic Cardiovascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank H. Logan M. D.
Address Hosp. for Women Date signed 12-10-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57835 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Camden St. New Joyce Hotel
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HUGH J. GRIFFITH

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~ or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Dicey Griffith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27th 1882

8. AGE: Years	Months	Days	If less than one day
64	11	13	hr. min.

9. Birthplace Iowa
(Town, county, and state)
10. Usual Occupation Printer
11. Industry or business News-Post

FATHER
12. Name Joseph Griffith
13. Birthplace Wales

MOTHER
14. Maiden Name Margaret Roberts
15. Birthplace Wales

16 (a) Informant Wm J. Miller
(b) Address 520 Munsey Bldg

17 (a) Burial (b) Date thereof 12/12/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 21 E. St. Paul St.

19 (a) (b)
(Date rec'd by registrar) DEC 11 1947 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1947, at M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Ryle M.D.
Medical Examiner.
Date signed 12-10-47

657836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 657836

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 876 Union Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 876 Union Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Eva May Loane

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Harry A—

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 04-7-1879

8. AGE: Years 68 | Months 3 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Phila. Penna (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Mary English

15. Birthplace Phila - Penna.

16 (a) Informant Wm H. Bedford

(b) Address 1304 W. Belvedere Ave

17 (a) Thursday (Burial, cremation, or removal) (b) Date thereof 12/11/47 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore

18 (a) Funeral director Wm Cook Inc

(b) Address 1717 St Paul St

DEC 11 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 9 1947, at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1947 to DEC. 9 1947, and that I last saw her alive on Dec. 8 1947.

Immediate cause of death	Duration
Hypertension cardiovascular renal disease	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M.D. M. D.

Address 3902 Greenmount Ave. Date signed 11 DEC. 47

X

G57837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57837 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 3 6
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 147 W. Hamburg st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Estelle McGill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/1906

8. AGE: Years	Months	Days	If less than one day
41	5	24	hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Factory Work

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Catherine Wilson
(b) Address 1005 Sharp Street

17 (a) Removal (b) Date thereof 12/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Andrews
Location South Carolina

18 (a) Funeral director Isaac L Brown & Son
(b) Address 1911 Montgomery St

19 (a) DEC 11 1947 (b) Courtesy of Williams Mort.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1947, at 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1947, to 12/9 1947, and that I last saw h.er alive on 12/2 1947.

Immediate cause of death Intracerebral Hemorrhage — Duration 5 hrs

Due to Hypertensive cardio-vascular disease — Duration unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Fillow M. D.
Address South Balto Gen Hosp Date signed 12/10/47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 157838

157838 CM. 115684 (937)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 Days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 508 N. Carrollton Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Hall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
74 ?			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-12-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto City

18 (a) Funeral director Isaiah L Brown & Son

(b) Address 1600 Montgomery St.

19 (a) DEC 11 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 - 1947, at 7.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 - 1947 to Dec. 7 - 1947 and that I last saw him alive on Dec. 7 - 1947

Immediate cause of death	Duration
(a) Cerebrovascular Accident.	1 wk
Due to H.C.V.D.	6 yrs
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Edmund Beadle M.D.

Address Balto City Hosp Date signed Dec 8 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

Registered No. 657839

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 S. Broadway
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** ERVIN WILLIAM DEXTER

3 (b) If veteran, name war

3 (c) Social Security Account No. 456-12-8149

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1893

8. AGE: Years	Months	Days	If less than one day
54	10	13	hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation none

11. Industry or business Seafarer

FATHER
12. Name Isaac Dexter
13. Birthplace Little Rock, Ark.

MOTHER
14. Maiden Name Gertrude Carpenter
15. Birthplace ?

16 (a) Informant Records
(b) Address U.S. Marine Hospital

17 (a) Burial (b) Date thereof Dec 11 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Evergreen Baltimore
Location Balto. Md.

18 (a) Funeral director Ellsworth Agnew
(b) Address 391 Liberty Hghts Ave

19 DEC 11 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1947, at 3.20 a.m.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty Degeneration of Liver
Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl K. Royston M.D.
Medical Examiner.
Date signed 12-10-47

E.L. Lubinsky M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

657840 / 53

Registered No. 057840

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2308 Eutaw Pl
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 Eutaw Pl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Sendenberg

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Sidney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Charles
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (b) Date thereof 12-11-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Tefilo
Location Wenden Mill Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 200 Eutaw Place

19 (a) Dec 11 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

35

20. DATE OF DEATH 12-11- 1947, at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946, to Dec. 11 1947, and that I last saw h er alive on Dec. 11 1947

Immediate cause of death	Duration
CARCINOMA OF EAR	22 MOS
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July 1946

Major findings of operation: CARCINOMA OF EAR

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J Hunecfarb M.D.

Address 1801 Eutaw Pl. Date signed 12/14/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C57841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C57841

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 859 McAleer Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr MAX COHEN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Maurice Cohen
(b) Address 3011 E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 216 Eutaw Place

19 (a) DEC 11 1947 (Date rec'd by registrar) (b) Huntingtown Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1947 at 10:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1947 to 12-10 1947 and that I last saw h.m. alive on 12-10 1947.

Immediate cause of death Myocardial insufficiency — Duration
Due to Myocardial infarction
Due to Coronary artery sclerosis and occlusion
Other Conditions Pulmonary edema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan J. Wolinsky M. D.
Address Sinai Hosp. Date signed 12-11-47

VS 150

MARGIN RESERVED FOR USE OF DIRECTOR

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 657842

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hos.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 31 Newburg Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Heubeck Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Eliz. Hunt Heubeck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1893

8. AGE: Years 54 | Months 9 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Heating Engr.

11. Industry or business

FATHER 12. Name Christian F Heubeck

13. Birthplace Md.

MOTHER 14. Maiden Name Louisa Miller

15. Birthplace Md

16 (a) Informant Mrs. Andrew Heubeck Sr

(b) Address 31 Newburg Ave Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md.

18 (a) Funeral director J. C. Hegenbottom

(b) Address Ellicott City Md

19 DEC 11 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1947 at 11 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1922 to Dec 10 1947 and that I last saw him alive on Dec 9 1947

Immediate cause of death Coronary Occlusion — Duration

Due to Arterio-sclerosis

Due to Diabetes

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Wainwright Ford

Address 22 S. Preston St. Date signed 12/14/47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C57843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 163H

Registered No. C57843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27-28
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Parkley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vivian B. Wolfing

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Harold F. Wolfing
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1917

8. AGE: Years	Months	Days	If less than one day
30	5	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Malcolm L. Ruth
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Beulah M. Folks
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Harold F. Wolfing
(b) Address 3309 Parkington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 11 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1947 at 2.30 P.M.

21. I certify that I took charge of the remains described above, held an insp.&inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury 12-10-47 2 a. M.
(b) Where did injury occur? 3309 Parkley Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 6 burners on, unlit

23. Signature Earl L. Kruger M.D. Medical Examiner.
Date signed 12-10-47

G57844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G57844

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 N. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BENJAMIN KENNY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mazie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1920

8. AGE: Years	Months	Days	If less than one day
27	9	13	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Thomas J Kenny
13. Birthplace Md.

MOTHER
14. Maiden Name Adlaide Corbin
15. Birthplace Md.

16 (a) Informant Mazie Kenny
(b) Address 2644 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 11/47 (month) (day) (year)
(c) Cemetery or crematory Dulaney Memorial Gdns
Location

18 (a) Funeral director Mrs. Cora A. Elliott & Dept
(b) Address 1129 N. Caroline St

19 (a) DEC 11 1947 (Date rec'd by registrar) (b) Interment for Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1947, at 3.20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture dislocation of 7th cervical vertebra - injury to Spinal Cord

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-6-47 at 8.30 p. M. 12/4
(b) Where did injury occur? 21st & Barclay St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Driver- struck automobile

23. Signature Earl L Royer M.D. Medical Examiner.
Date signed 12-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 057845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 Aull St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALKER LEWIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary Jane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE:	Years	Months	Days	If less than one day
	43			hr. min.

9. Birthplace Caroline County Va.
(Town, county, and state)
10. Usual Occupation Florist
11. Industry or business

FATHER
12. Name Walker Lewis
13. Birthplace Va.

MOTHER
14. Maiden Name Sallie Taylor
15. Birthplace Va.

16 (a) Informant Mary Jane Lewis
(b) Address 644 Aull St

17 (a) Burial (b) Date thereof Dec 13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. County Md

18 (a) Funeral director Mrs. Lottie A. Elliott Dept
(b) Address 1129 N. Carlton St

19 (a) DEC 11 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1947, at 9.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage,
spontaneous
Due to Hypertension R.V.
Disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royster M.D.
Medical Examiner
Date signed 12-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G57846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Shellbanks Road
(c) Hospital or institution: Home. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 5 1/2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 25 Cherry Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Shellbanks, Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME LeRoy HAGANS

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife LeRoy HAGANS
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) JAN. 18, 1921

8. AGE: Years	Months	Days	If less than one day
26	10	22	— hr. — min.

9. Birthplace Lillieton, N. C. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business —

FATHER 12. Name	William KeArney
FATHER 13. Birthplace	Halifax Co, N.C.
MOTHER 14. Maiden Name	Mattie Perry
MOTHER 15. Birthplace	Halifax Co. N.C.

16 (a) Informant LeRoy HAGANS
(b) Address 1010 S/hellbanks, Road
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 13/47 (month) (day) (year)
(c) Cemetery or crematory Location Loudelon n. Carlings
18 (a) Funeral director Mrs Pollo Ellis Hoff
(b) Address 1129 N. Carlins
19 DEC 11 1947 (b) [illegible] Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 10 1947 at 1140 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2, 1947 to Dec 10, 1947 and that I last saw h er alive on Dec. 9 1947.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other Conditions Koch's Injection	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jerry L. Luck M. D.
Address 303 Bridgeview Date signed 12/10/47

VS 150

G57847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G57847

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2834 Huntingdon Ave
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milfred M. Miller.

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Vilma E. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23, 1895

8. AGE: Years	Months	Days	If less than one day
52	-	16	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Conductor
11. Industry or business Penna R.R.

FATHER
12. Name John B. Miller
13. Birthplace Maryland.

MOTHER
14. Maiden Name Alberta M. Miller
15. Birthplace Maryland.

16 (a) Informant Vilma E. Miller.
(b) Address 2834 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13/47 (month) (day) (year)
(c) Cemetery or crematory Hereford.
Location Balto Co. Md.

18 (a) Funeral director Thomas F. Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) DEC 11 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1947, at 6 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1947 to 12/9 1947 and that I last saw him alive on 12/9 1947.

Immediate cause of death	Duration
Glomerulo nefolitis	10 mos
Due to	
Due to	
Other Conditions Valvular Heart, Mod. degree	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Clark Hoff M.D.
Address 2020 N. Charles Date signed 12/10/47

130

G57848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. G57848

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town ~~Balto.~~ MARRIOTTSVILLE
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~55 Prospect Ave.~~ (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Tribbett.
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-07-1517

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	~~M~~ S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1901

8. AGE: Years	Months	Days	If less than one day
46	6	13	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Painter.
11. Industry or business

FATHER
12. Name Reinhold.
13. Birthplace Germany.

MOTHER
14. Maiden Name C. Richstein
15. Birthplace Pennsylvania.

16 (a) Informant Mrs. Litzau. Sister
(b) Address 3632 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Harry A. Wiltze
(b) Address 4141 Reisterstown Ave

19 (a) DEC 11 1947 (Date filed by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1947, at 3 15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29 1947 to 12/10 1947 and that I last saw alive on 12/10 1947

Immediate cause of death Cardiac failure
Coronary Sclerosis
Due to Cut + Poison

Duration

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Mantz
Address Baltimore Date signed 12/10/47 M.D.

057849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57

Registered No. 057849

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County.....
(c) City or town Parsons (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Richard Agee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color of race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1929

8. AGE: Years 18 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name Richard Agee
13. Birthplace Virginia

MOTHER 14. Maiden Name Stump
15. Birthplace West Virginia

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/18/47 (month) (day) (year)
(c) Cemetery or crematory.....
Location Parsons, W. Va.

18 (a) Funeral director F. O. Cole
(b) Address 1200 N. Lombard St

19 (a) DEC 11 1947 (Date rec'd by Registrar) (b) Huntington, W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1947, at 7 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1947, to Dec 11 1947 and that I last saw h[illegible] alive on Dec 11 1947.

Immediate cause of death	Duration
Cerebral Edema	24 hrs.
Due to Brain Tumor	4 wks.
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Dec 11 1947

Major findings of operation: Increased Intracranial Pressure

of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature [illegible]

Address Johns Hopkins Hosp. Date signed 12/11/47 M. D.

G57850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 S. Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 S. Kenwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Panowicz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Poland

MOTHER 14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Miss Mary Panowski
(b) Address 1104 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location Highland & Lwon

18 (a) Funeral director Stephen J. Fiatkowski
(b) Address 1000 S. Kenwood Ave

19 DEC 11 1947 (Date rec'd by Registrar) (b) Huntington Wills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8-47 19 , at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Dec 8 1947 and that I last saw her alive on Dec 8 1947

Immediate cause of death	Duration
Myocardial Degeneration	1 mo
Due to Cerebral Thrombosis	2 wks
Due to Influenza	3 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. H. Hemmyann M. D.
Address 1706 E. 23rd St Date signed 12/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

File No. 109761
G57851

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

3 G57851
Registered No. 128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos.
(e) Length of stay in Baltimore (yrs., moe., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [redacted] 713 N. Duncan
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Cook Matthews

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rosa Matthews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1871

8. AGE: Years	Months	Days	If less than one day
76	8	17	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Matthews
13. Birthplace N. C.

MOTHER
14. Maiden Name Kate Cook
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore Md
18 (a) Funeral director Frank Brockdorf
(b) Address 749 Eastern Ave

19 DEC 11 1947 (b) Huntington Williams, Registrar
(Accepted by Registrar)

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Dec. 9 19 47 at 11.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 19 47 to Dec. 9 19 47 and that I last saw him alive on Dec. 9 19 47.

Immediate cause of death	Duration
Pulmonary Tuberculosis	5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Dwight W. Parks M. D.
Address Balt City Hosp Date signed 12-10-47

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57852 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt City
(c) City or town Baltimore 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 Webster St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John J. Frick, Senior

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W- ~~Married~~

6 (b) Name of husband or wife Julia C. Frick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5, 1878

8. AGE: Years	Months	Days	If less than one day
69	1	4	hr. min.

9. Birthplace S. Carolina (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Railroad engineer

FATHER
12. Name Otto Frick
13. Birthplace Germany

MOTHER
14. Maiden Name Mebanore
15. Birthplace U

16 (a) Informant Pauline Frick, daughter
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross. Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 14[illegible] Light St, Baltimore, Md.

DEC 11 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9-1947 at 9:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8-1947 to 12-9-1947 and that I last saw him alive on 12-9-1947

Immediate cause of death	Duration
Acute myocardial failure	
Due to Hypertensive cardio-vascular disease	Chronic
Due to Generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles B. MacDonald M. D.
Address 1753 Light St Date signed 12-9-47

VS 150

G57853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G57853
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Druid Hill ave
(b) Street address 1620 Jewel Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Jewel Avenue
1626 W Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Levenia) LARONIA NEWMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Cecil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1926

8. AGE: Years	Months	Days	If less than one day
21	2	0	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Howard Thompson
13. Birthplace Maryland

MOTHER
14. Maiden Name Amelia ?
15. Birthplace Maryland

16 (a) Informant Mrs. Jeanette Taylor
(b) Address 505 Oliver street

17 (a) Burial (b) Date thereof 12/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna, Ave

19 (a) Date received 1947 (b) Washington Williams, Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at 11.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Head
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-8-47 at 11 P. M.
(b) Where did injury occur? 1620 Jewel Ave. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms-

23. Signature Earl L Ruzzo M.D.
Medical Examiner
Date signed 12-9-47

G57854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57854

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 930 Pierce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 Pierce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Rebecca Bivens.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Severn Thomas Bivens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1903

8. AGE: Years 44 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Henry Lee.
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Susan Jefferson
15. Birthplace Richmond Virginia

16 (a) Informant Mary Smith
(b) Address 930 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Wm Hyte Robertson
(b) Address 322 N. Schroeder St

19 (a) (Date received by registrar) DEC 11 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Dec 9 1947, and that I last saw him alive on Dec 8 1947.

Immediate cause of death	Duration
Recurrent Hemiplegia	4 yr.
Due to Hypertension	4 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas D Graham M.D.
Address 518 N Schroeder St. Date signed 12/10/47

G57855 BRITTON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1113

G57855 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Wilmer Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Wilmer Court. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie Britton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	married

6 (b) Name of husband or wife George W. Britton.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1890

8. AGE: Years	Months	Days	If less than one day
57	8	6	hr. min.

9. Birthplace Easton, Md. (Town, county, and state)
10. Usual Occupation Laundress.
11. Industry or business

FATHER
12. Name William Whittington.
13. Birthplace Md.

MOTHER
14. Maiden Name Katie Gooby.
15. Birthplace Md.

16 (a) Informant Mable Britton.
(b) Address 1213 Wilmer Court.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 327 N. Schroeder St

19 DEC 11 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1947, at 0P M

21. I certify that I took charge of the remains described above, held an Aug Ed Aut thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William F. Gelpcke M.D. (Medical Examiner)
Date signed Dec 9, 1947

VS 151

657856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 657856

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 b. Fremont St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 S. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irene Brown.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	married

6 (b) Name of husband or wife Edward Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1902

8. AGE: Years	Months	Days	If less than one day
45	-	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ezekiah Lawson.
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Rich.
15. Birthplace Virginia

16 (a) Informant Edward Brown.
(b) Address 812 S. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs. Katie R. William.
(b) Address 322 N. Schroeder St.

19 (a) DEC 11 1947 (Date rec'd by registrar) (b) Washington Hill Registered, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1947 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5/1944 to 12/9/1944, and that I last saw her alive on 12/8/1947.

Immediate cause of death: 6 hr. Val. Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter S. Taylor
Address 322 Harlem Ave Date signed 12/10/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C57857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93E

Registered No. C57857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 E.23rd Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 503 E.23rd Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John A.Reed

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife: Maggie Nolte
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 2,1882

8. AGE: Years	Months	Days	If less than one day
65	9	7	##### min.

9. Birthplace Baltimore,Md. (Town, county, and state)
10. Usual Occupation Store Keeper
11. Industry or business Confectionery

FATHER
12. Name George A.Reed
13. Birthplace Baltimore,Md.

MOTHER
14. Maiden Name Margaret Smith
15. Birthplace Baltimore,Md.

16 (a) Informant Mrs.Emma M.Pistel (Sister)
(b) Address 5406 Fortieth Ave.Hyattsville,Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.Balto:Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1235 Harford Avenue

19 DEC 11 1947 (Date rec'd by registrar) (b) Washington Williams, Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9th., 19 47; at M

21. I certify that death occurred on the date above stated; that I attended deceased from August 19 47 to Dec. 9th 19 47 and that I last saw h[illegible] alive on Dec 19 47.

Immediate cause of death	Duration
Coronary Artery Occlusion	2 hours
Due to Coronary Artery Disease	2 hours
Due to	
Other Conditions Hypertension	6 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Wilk M. D.
Address 582-E.22nd St. Date signed 12/10/47

G57858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 43

Registered No. G57858

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Arundel Village (Balto. 25)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5210 Wasona Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Calvin Pfieffer

3 (b) If veteran, name war: Vet.

3 (c) Social Security Account No. # 214-03-1201

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ann Pfieffer

6 (c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): June 10, 1910

8. AGE: Years 37 | Months 5 | Days 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Dry cleaning business

11. Industry or business: Drivers

FATHER
12. Name: Albert Pfieffer
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Jennie Goodwin
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Ann Pfieffer
(b) Address: 5210 Wasona Ave, Balto. 25.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/47 (month) (day) (year)

(c) Cemetery or crematory: Baltimore National
Location: Baltimore, Md.

18 (a) Funeral director: Thomas W. Singleton
(b) Address: Glen Burnie, Md.

19 (a) DEC 11 1947 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 8 19 47 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Dec. 8 1947, and that I last saw h im alive on Dec. 8, 1947.

Immediate cause of death: Meningitis — Duration: 2 months

Due to: Torula infection

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Lindsay Krohn

Address: U S Marine Hospital Date signed: 12/8/47

VS 150

X

057859 CM 110019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 057859

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 57 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 E. Cross ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Stevens

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Harry Stevens (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13 -1878

8. AGE: Years	Months	Days	If less than one day
69	-	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Willieminie Schoen
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12-47 (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location

18 (a) Funeral director Chas P Powell
(b) Address 2427 Edmondson Ave

19 (a) Dec 13 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 - 1947, at 8.40A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 18 - 1947 to Dec. 9 - 1947. and that I last saw her alive on Dec. 9 - 1947.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Roberson Jr M. D.
Address Balt City Hosp Date signed 12/10/47

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57860

444873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G57860

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Cambridge,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 434 Washington Elms.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Lyons Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-27-40

8. AGE: Years	Months	Days	If less than one day
7	1	14	hr. min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William J Lyons
13. Birthplace Mass.

MOTHER
14. Maiden Name Frances Lena Han.
15. Birthplace Mass.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Malden Mass

18 (a) Funeral director Frank H Sarg
(b) Address 14 W 36 St

19 (a) (b) Huntington Williams, M.D.
(Signature of local registrar)

DEC 13 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 - 1947 at 9 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5- 1947 to 12-10-1947, and that I last saw him alive on 12-10-1947.

Immediate cause of death	Duration
Hydrocephalus	Life
Due to	
Due to	
Other Conditions Congenital Heart Disease	Life

(Include pregnancy within 3 months of death)

Date of operation 12-2-47
Major findings of operation: Tetralogy of Fallot
of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Cleg M. D.
Address Johns Hopkins Hosp. Date signed 12-11-47

G57861

GM. 115456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G57861

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora E. Frederick

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Henry (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20 -1863

8. AGE: Years	Months	Days	If less than one day
84	1	19	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Shumaker (D)
13. Birthplace PA.

MOTHER
14. Maiden Name Mary Dethaven (D)
15. Birthplace PA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/ 12/47 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 11 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 - 1947, at 6.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 - 47 to Dec. 9-1947, and that I last saw her alive on Dec. 9- 1947.

Immediate cause of death Adenocarcinoma of Colon with Generalized Metastases — Duration Yrs. Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-22-47 & 9-16-47

Major findings of operation: Ca. of colon with metastases to lymph nodes & liver

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irvin E. Nitterville, M. D.
Address Balt. City Hosp. Date signed Dec 10 1947.

G57862 B.C. # 9162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

G57862 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town 1531 Linden Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Ave Moyne Pa (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Dietz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/14/47

8. AGE: Years | Months | Days: 6 weeks | 28 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Dietz
13. Birthplace Pa

MOTHER
14. Maiden Name Betty A Staley
15. Birthplace W. Virginia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-11-47 (month) (day) (year)
(c) Cemetery or crematory
Location Harrisburg Pa

18 (a) Funeral director Wm G. Maran
(b) Address 3000 E. Baltimore St 2f

19 (a) 11 (1947) (b) Rec'd by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Resp failure	
a Bronchopneumonia	
Due to Cystic fibrosis pancreas	6wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Scriger Jr. M. D.
Address Johns Hopkins Date signed 12-11-47

G57863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 928

G57863
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 N. Bentalou st
(c) Hospital or institution: 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Bentalou st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry R. Immler

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) ~~Single~~, married, ~~widowed, or~~ divorced: Married
6 (b) Name of ~~husband or~~ wife Grace M. Immler
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 15 - 1869
8. AGE: Years 78 | Months 9 | Days 25 | If less than one day hr. min.
9. Birthplace Balto. Md (Town, county and state)
10. Usual Occupation Retired - Painter
11. Industry or business B & O R. R.
FATHER 12. Name Unknown Immler
13. Birthplace "
MOTHER 14. Maiden Name "
15. Birthplace "
16 (a) Informant Mrs. Grace M. Immler
(b) Address 109 N. Bentalou st
17 (a) Burial (b) Date thereof 12/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st
DEC (a) 12 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 - 1947, at 4a M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1947 to Dec 10 1947 and that I last saw h~~im~~er alive on Dec 9 1947

Immediate cause of death	Duration
Bronchopneumonia	
Due to Mitral	
Insufficiency	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Walter Hagerstown M. D.
Address 1429 W Fayette St Date signed 12/11/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 G

Registered No. G57864

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 65

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Moses Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace: Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George Taylor
13. Birthplace Va

MOTHER 14. Maiden Name Mary Farris
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec 14 47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A.A. County

18 (a) Funeral director Mrs. Estt Williams Dgt
(b) Address 1129 N. Carolina St

DEC 12 1947 (c) Registered Herrington for Williams Registrar

VS 150

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Dec 10 1947, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1947 to Dec 10 1947 and that I last saw him alive on Dec 10 1947.

	Duration
Immediate cause of death Congestive Heart Failure	
Due to Aortic Insufficiency	
Due to Syphilis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman M. Millinkoff M. D.
Address Johns Hopkins Hosp. Date signed 12/19/47

X

657865

JL - 113345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

657865 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 256
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 148da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Brady St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Eva Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1910

8. AGE: Years 36 | Months 11 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Lunch Room Worker

11. Industry or business

FATHER
12. Name George Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Elsie Widgeon
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14 47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location

18 (a) Funeral director Mrs. Ruth R. Ellwood Dyer
(b) Address 129 N. Gay St. Huntingtown, Williamsport, Md.

19 DEC 12 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Dec. 10 1947, at 12.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1947 to Dec. 10 1947, and that I last saw h alive on Dec. 10 19 47

Immediate cause of death tuberculosis of lungs, for advanced, bilateral, tuberculous laryngitis, pleuritis, salpingitis, pericolitis — Duration: 3 mo.

Due to T.B. of vertebrae; T.B. of Kidneys; T.B. of spleen, T.B. of liver

Due to

Other Conditions syphilis B. wassermann

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd W. Parks M. D.

Address Bal. City Hosp. Date signed 12-12-47

57868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 652866

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4324 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Brill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Louis Sherman
13. Birthplace Russia

MOTHER
14. Maiden Name Leah ?
15. Birthplace Russia

16 (a) Informant Milton Brill
(b) Address 716 W Franklin St

17 (a) Burial (b) Date thereof Dec, 12, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem.
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 DEC 12 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1947, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1947 to Dec 11 1947, and that I last saw h[illegible] alive on Dec 11 1947.

Immediate cause of death	Duration
Gastric fistula - post op from gastric resection.	
Due to Carcinoma of the stomach	
Due to	
Other Conditions Diabetes mellitus arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)

Date of operation Nov. 6, 1947

Major findings of operation: Ca of stomach extending into lower esophagus

of autopsy Gastric fistula

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin Shapiro M. D.
Address Sinai Hospital Date signed 12/11/47

X

G57867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G57867

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Lochearn and Pat K River (If outside city or town limits, write RURAL and give town)
(d) Street No. Deaford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Menzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21 1868

8. AGE: Years 79 | Months 2 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Wm Smith
13. Birthplace Balto

MOTHER
14. Maiden Name Dorr Kenner
15. Birthplace

16 (a) Informant Albert Taylor
(b) Address 31 Deaford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Wilson Funeral Home
(b) Address 2008 Arlington Ave

19 (a) Dec 12 1947 (Date received by registrar) (b) [illegible] Registrar

DEC 12 1947
VS 193 A A 1A

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9/ 1947, at 7 32 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1946 to Dec 9 1947, and that I last saw h~~e~~r alive on Dec 9 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 weeks
Due to: Hypertensive Cardio-Vascular disease	10 years.
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A L Kolodney M. D.
Address 43 Edgewater Apts Date signed Dec 9, 1947.
X Baltimore 21, Md.

G57868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131A

G57868 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Born Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE BOWEN BIAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1886

8. AGE: Years	Months	Days	If less than one day
61 60	1	24th	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Eleanor Roberts
(b) Address 702 Born Court.

17 (a) Burial (b) Date thereof 12-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 548 W. Biddle St.

DEC 12 1947 (b) Hunting Fox Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1947 at 5.35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension
Cardiac vascular renal
disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 12-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657869

BALTIMORE CITY HEALTH DEPARTMENT one

CERTIFICATE OF DEATH 95C

Registered No. 657869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5512 Greenhill Ave. 76
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5512 Greenhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie M. Berger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31st 1861

8. AGE: Years	Months	Days	If less than one day
85	11	11	hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Berger
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Axe
15. Birthplace Germany

16 (a) Informant John Kilian
(b) Address 4409 Minnesota Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 13 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Rd.

19 Date received by Registrar 12 1947 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10th 1947, at 105 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5 1947, to 12-9 1947, and that I last saw her alive on 12-9 1947.

Immediate cause of death	Duration
Cardiac Insufficiency	
Due to Arteriosclerosis	many yrs
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mat R. English M. D.
Address 5713 Belair Rd Date signed 12-11-47

VS 150

G57870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94A

G57870 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2223 Washington Blvd
(c) Hospital or institution: 25-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James P. Keyser

3 (b) If veteran, name war W.W.I

3 (c) Social Security Account No. 212-22-6906

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma Keyser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (Feb) 12 - 1893

8. AGE: Years	Months	Days	If less than one day
53	10	29	hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Retired

11. Industry or business Stockster

FATHER
12. Name Henry Keyser
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Emma Keyser
(b) Address 2223 Wash'n Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15-47 (month) (day) (year)
(c) Cemetery or crematory U. S. National Cem
Location Balto Md

18 (a) Funeral director Edward Foulkrod
(b) Address 359 Washington Blvd

19 DEC 12 1947 (Date rec'd by Registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1947, at 6.40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1946 to Dec 11 1947, and that I last saw h.e alive on Dec 4 1947

Immediate cause of death	Duration
Coronary Occlusion	6 min.
Due to Coronary Artery Disease	2 Yrs.
Due to	
Other Conditions Asthmatic	1 1/2 Yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Urlock, Jr. M.D.
Address 1227 Wash Blvd Date signed 12/12/47

VS 150

G57871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G57871
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Dover St
(c) Hospital or institution: 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Dover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Dean

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah A. Dean
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) July 30-1866

8. AGE: Years 81 | Months 4 | Days 9 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm H. Dean
13. Birthplace

MOTHER
14. Maiden Name Laura S. Kielholtz
15. Birthplace

16 (a) Informant Sarah A. Dean
(b) Address 1814 Dover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto Md

18 (a) Funeral director Pott & Baum Walter
(b) Address Pott & Stocksdale

19 Dec 10 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1947, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947 to Dec. 9 1947, and that I last saw him alive on Dec 8, 1947.

	Duration
Immediate cause of death: Cerebral Embolism	
Due to: Chr. Myocarditis	
Due to:	
Other Conditions: Chr. Nephritis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Hannon M.D.
Address 820 Medical Arts Bldg Date signed 12/9/47 M. D.

93 D

G5 7872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1921

G5 7872 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Madison Ave.,
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Madison Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Vaughan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1852

8. AGE: Years 95 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Vaughan
13. Birthplace Virginia

MOTHER
14. Maiden Name Joan ?
15. Birthplace Virginia

16 (a) Informant Mrs. Lillie Hatch
(b) Address 2001 Madison Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

19 (a) DEC 12 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1947, at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1947, to Dec 10 1947 and that I last saw him alive on Dec 8 1947.

	Duration
Immediate cause of death Chronic Valvular Heart Disease	3 yrs.
Due to Arteriosclerosis	3 Mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. William Frey M.D.
Address 928 Penna Ave Date signed 12/11/47

657873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 657873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Queen Anne~~ KENT
(c) City or town Rock Hall.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) J
If yes, name country

3 (a) FULL NAME Mary Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Marvin Scott.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1892

8. AGE: Years: 55 | Months: 5 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Rock Hall, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel Hopkins
13. Birthplace: Rock Hall, Md.

MOTHER
14. Maiden Name: Carrie Thompson
15. Birthplace: Rock Hall, Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Rock Hall
Location Queenanne Co. Md.

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address 322 N. Schroeder Sts.

19 (a) Dec 12 1947 (Date received by registrar) (b) Huntingtown Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1947, at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 to 1947
and that I last saw h[er] alive on Dec 10 1947.

Immediate cause of death: Pneumonia,
Due to: R.U.L., R.M.L., R.L.L., L.U.L.
Organism not determined

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Truman J. Hoppes

Address Galesville, Md. Date signed 12/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

Registered 057874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Pearl Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1893

8. AGE: Years	Months	Days	If less than one day
52 54	10	7	hr. min.

9. Birthplace Balto. City, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Agnes Harriday
15. Birthplace Baltimore, Md.

16 (a) Informant Alexander Williams
(b) Address 150 Winters Avenue-Catonsville, Md.

17 (a) Burial (b) Date thereof Dec. 14, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Oella, Maryland.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 12 1947 Katie R. Williams M.D.
(Date rec'd by Registrar) (Signature of Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1947, at 8.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema
Due to Hypertensive C.V. Disease
Other Conditions Syphilitic Aortitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyer M.D.
Medical Examiner.
Date signed 12-10-47

G57875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G57875

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Traction Street
(c) Hospital or institution: 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Traction Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HOLLEY BUCHANAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1886

8. AGE: Years	Months	Days	If less than one day
61	5	18	hr. min.

9. Birthplace Pineygrove, Md. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name George Buchanan
13. Birthplace Pineygrove, Md.

MOTHER
14. Maiden Name Alice Dett
15. Birthplace Baltimore Co., Md.

16 (a) Informant Lawrence Buchanan
(b) Address 1709 Etting Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)
(c) Cemetery or crematory St Peter Cemetery
Location Baltimore

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

19 DEC 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1947, at 7¼ M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1947 to 12/11 1947, and that I last saw h~~e~~ alive on 12-10 1947.

Immediate cause of death	Duration
Uremia Carcinoma of Prostate	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Jackson M.D.
Address 600 N Eutaw Street

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 657876

657876 1313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 S.Robinson St.
(c) Hospital or institution: 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 S.Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Francis Hall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife John W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch.11,1859

8. AGE: Years 88 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Dorchester Co.Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name George W.Jones
13. Birthplace Dorchester Co.Md.

MOTHER
14. Maiden Name Johanna Tall
15. Birthplace Dorchester Co. Md.

16 (a) Informant Mrs. Hall
(b) Address 427 S.Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway

19 (a) DEC 12 1947 (Date rec'd by Registrar) Thos. J. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1947 about 5P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1947 to 19 , and that I last saw her alive on Dec 2 1947

Immediate cause of death: Chronic Nephritis — Duration
Chronic Bronchitis
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Joseph Toulson M.D.
Address 441 S. Ellwood Ave. Date signed 12/10/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write to the causes of death clearly and legibly.

657877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

657877 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 8-7 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626- E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME TURNER LEE TILLERY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Earl Tillery

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years 28 | Months | Days | If less than one day hr. min.

9. Birthplace Cofield nc (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Walter Carter

13. Birthplace nc

MOTHER 14. Maiden Name Emma Dowing

15. Birthplace nc

16 (a) Informant Earl Tillery

(b) Address 1626 E. preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Aylesford Md.

18 (a) Funeral director Robert E. Wieda

(b) Address 515 McCulloh St

19 (a) DEC 12 1947 (Date rec'd by registrar) (b) Interred for Nottingham, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1947, at 7 AM

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis

Due to

Other Conditions Hypertension, Myocardial Infarction

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L. Royster M.D. Medical Examiner.

Date signed 12-10-47

VS 181

56E

G57878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G57878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 Aisquith St.
(c) Hospital or institution: S.2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEGEASED:
(a) State Md (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Aisquith St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUVENIA NEWLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: C.

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: JOHN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-14-1885

8. AGE: Years 61 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace VA. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name RANdolph SMALL
13. Birthplace VA.

MOTHER
14. Maiden Name DIANA FLEET
15. Birthplace Md

16 (a) Informant Joseph B. Locke Jr
(b) Address 1364 N. CENTRAL AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-13-47 (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location AA. County, Md.

18 (a) Funeral director Joseph B. Locke Jr
Address 1304 N. Central Ave

DEC 12 1947
(Delivered by registrar) (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1947, at 6A-M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1947, to 12-9 1947, and that I last saw h[illegible] alive on 12-1 1947

Immediate cause of death	Duration
Acute Cardiac dilatation	immediate
Due to Cerebral Hemorrhage	2-6 hours
Due to Cardiovascular disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. E. Linwood
Address 121 Aisquith Date signed 12-11-47

VS 150

G57879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G57879

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital. (If not in hospital or institution, give residence address.)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 East Balt. St., City (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Estor Jane Hetzer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife: Wm. Frank M. Hetzer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1892

8. AGE: Years	Months	Days	If less than one day
55	0	11	hr. min.

9. Birthplace New York, N.Y. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business none

FATHER
12. Name Archie Sparling
13. Birthplace New York, N.Y.

MOTHER
14. Maiden Name Mary Lynch
15. Birthplace Ireland

16 (a) Informant husband
(b) Address 1630 East Balt. Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (mo.) (day) (yr.)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Fredericks & Dole
(b) Address 1200 W. Lombard St.

DEC 12 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1947, at 12:22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947 to Dec. 10 1947 and that I last saw her alive on Dec. 10 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Accident	
Due to Hypertension + arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James M.C. Finney M.D.
Address Union Memorial Hosp. Date signed 12-10-47

X

(57880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered No. 57880

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1232 WALL ST
(c) Hospital or institution: 24, 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 WALL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) J
If yes, name country

3 (a) FULL NAME LAURA E MORAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEM

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: JOHN MORAN

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) DEC 27 - 188[illegible]

8. AGE: Years 64 | Months 11 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace: BALTIMORE MD
(Town, county, and state)

10. Usual Occupation: HOUSE WORK.

11. Industry or business —

FATHER
12. Name: WILLIAM H COLLINS
13. Birthplace: BALTIMORE MD

MOTHER
14. Maiden Name: ELIZABETH MILLER
15. Birthplace: BALTIMORE MD

16 (a) Informant: MRS LEROY DORSEY
(b) Address: 1232 WALL ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC-15-47 (month) (day) (year)
(c) Cemetery or crematory: LOUDON PARK.
Location: FREDERICK ROAD

18 (a) Funeral director: Bernard C Hartz
(b) Address: 171 E West St

19 (a) DEC 12 1947 (Date rec'd by registrar) (b) Huntington for Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 11 1947, at 1:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1947, to 12/11 1947, and that I last saw her alive on 12/9 1947.

	Duration
Immediate cause of death: Arteriosclerosis	
Due to: Coronary Occlusion Disease	
Due to: Femoral Thrombosis	5 days
Other Conditions: Cerebral Thrombosis	10 days
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: E B Ellis M. D.
Address 107 E. West St Date signed 12-14-47

X

G57881

HEALTH DEPARTMENT—CITY OF BALTIMORE

G57881

CERTIFICATE OF DEATH

158

1. PLACE OF DEATH Vet of Amer Disp.

Registered No.

CITY OF BALTIMORE: (No. 418 W. Lexington St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Infant Aydelotte

If U. S. Veteran specify WAR.

(a) Residence: No. 2914 Parkwood Ave St., Ward 13-4

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Dec. 11, 1947

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				16 hrs. or 15 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md.

FATHER

13. NAME J Hugh Bonn

14. BIRTHPLACE (city or town) (State or country) Virginia

MOTHER

15. MAIDEN NAME Helen Aydelotte

16. BIRTHPLACE (city or town) (State or country) Balto. Md.

17. INFORMANT Mother

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place St. Peters Date Dec. 12, 1947

19. UNDERTAKER Geo A. Fahey

(Address) Fayette St & Fulton Ave.

20. FILED DEC 12 1947 19... Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. 11, 1947

22. I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1947, to Dec. 11, 1947

I last saw her alive on Dec. 11, 1947. Death is said to have occurred on the date stated above, at 5.30 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiorespiratory failure	12-11-(47)
Other contributory causes of importance:	

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

... If so, specify ...

(Signed) ... M. D.

(Address) Johns Hopkins Hosp

N. B.—WHITE PAPER should be used. Fill in all items carefully and completely. If any item cannot be supplied, write "unknown." AGE should be carefully supplied. Exact statement of information should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 057882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2600
(c) Hospital or institution: BALTIMORE CITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6210 Eastborne Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES VRONDISIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant ?
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12-47 (month) (day) (year)
(c) Cemetery or crematory Greek
Location Balto. Md.

18 (a) Funeral director Sanders Funeral Home
(b) Address 440 E. North Ave.

19 (a) Dec 12 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1947, at 6.15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSE OF DEATH Fracture Base Dural Laceration Fractures confirmed Due to Shock & Hemorrhage, Multiple

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-9-47 at 6 p. M.
(b) Where did injury occur? 5200 block Highland Ave. Baltimore
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian- struck by taxi

23. Signature Carl L. Voigt M.D.
Date signed 12-10-47 Medical Examiner.

G57883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194A

G57883
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .... 3215 Moravia Avenue
(c) Hospital or institution: 27-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Moravia Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA F. MEINFELDER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Marriei

6 (b) Name of husband or wife Frnest Meinfelder
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1885

8. AGE: Years	Months	Days	If less than one day
62	3	26	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Hackett
13 Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Jeanne Jenkins
15 Birthplace Maryland

16 (a) Informant Mr. Ernest Meinfelder
(b) Address 3215 Moravia Avenue

17 (a) Burial (b) Date thereof 12/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 12 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1947, at 2.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 19 . to 12-10 1947.
and that I last saw h[illegible] alive on 12-2 1947.

Immediate cause of death: Coronary Occlusion — Duration: 1 hour
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature C. W. Peake M. D.
4508 Hereford Rd Date signed 12-11-47

VS 193

657884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. 657884

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Tenn (b) County
(c) City or town R7D 5 Box 508 Memphis Tenn.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Princeton Road - 12
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irvin James Calvin

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	413-07-6316

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Carrie Calvin
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr) 8-28-80

8. AGE: Years	Months	Days	If less than one day
67	23	13	hr. min.

9. Birthplace Miss
(Town, county, and state)
10. Usual Occupation mechanical eng -
11. Industry or business Federal Compress Co.

FATHER
12. Name Thomas Calvin
13. Birthplace Miss

MOTHER
14. Maiden Name Teresa Nation
15. Birthplace Miss.

16 (a) Informant Mrs Carrie E. Calvin
(b) Address R. 5 B-508 Princeton Rd.-12 Memphis Tenn

17 (a) Burial (b) Date thereof 12-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Memorial Park
Location Memphis, Tenn

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 12 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 11 1947, at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1947 to Dec 11 1947, and that I last saw h[illegible] alive on Dec 11 1947

Immediate cause of death: Myocardial Infarction (Coll.) — Duration 1 hr

Due to: Coronary artery disease — 6 yrs

Due to: Atherosclerosis

Other Conditions: Brief uterine hemm. FBC
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 12-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G57885

1. PLACE OF DEATH: 700 Front St
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Glen Arm (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John B. Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1926

8. AGE: Years	Months	Days	If less than one day
21	2	25	hr. min.

9. Birthplace Glen Arm, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Bernard J Livingston
13. Birthplace Md

MOTHER
14. Maiden Name Anna J Livingston
15. Birthplace Glen Arm, Md

16 (a) Informant Bernard Chambers
(b) Address Glen Arm, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-47 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Long Green

18 (a) Funeral director Leonard J Ruck
(b) Address 5305 Harford Rd

19 (a) DEC 12 1947 (Date rec'd by registrar) (b) Forwarding Undertaker's Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1947, at 10 10 a.m.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/11 at found 7-2 a.m. p.m.
(b) Where did injury occur? Harbor American Legion Keyser
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury [illegible] drowned

23. Signature [illegible] M.D. Medical Examiner.
Date signed 12/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44A

G57886 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Moore Avenue
(c) Hospital or institution: 27-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Moore Avenue nr Old Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stella Luyens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Gus Luyens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1885

8. AGE: Years	Months	Days	If less than one day
62	7	2	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Rudolph Gerlach
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Helen Szczypinski
(b) Address Moore Avenue,

17 (a) Burial (b) Date thereof 12-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

DEC 12 1947 (b)
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to 10 Dec 1947 and that I last saw h.e.r. alive on 10 Dec 1947.

Immediate cause of death	Duration
Carcinoma Corpus Uteri	7 3-4 yrs
Due to	
Due to	
Other Conditions 2 marriages, Anaemia, Cachexia.	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: -
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Callahan M.D.
M. D.
Address 1011 Calvert St. Date signed 11 Dec 47

X

657887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1178

657887 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hospital 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Christopher Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie S. Nickol

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Maurice Nickol
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1895

8. AGE: Years	Months	Days	If less than one day
52	9	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James G. Bechtel
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Annie Holmes
15. Birthplace

16 (a) Informant Mr. Maurice Nickol
(b) Address 2812 Christropher Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) DEC 12 1947 (b) Huntington Williams Mort

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Dec 1947, at 2:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1947 to 12-11 1947, and that I last saw her alive on 12-11 1947.

Immediate cause of death Terminal Bronchial Pneumonia
Due to Retroperitoneal abscess perforated duodenal ulcer
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 11-14-47
Major findings of operation: acute cholecystitis, cholelithiasis
of autopsy: Dr. Peterson; ulcer

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph B. Schmuck M. D.
Address Franklin Sq. Hosp. Date signed 12-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G57888

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME N. WRIGHT CROWDER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8, 1888

8. AGE: Years	Months	Days	If less than one day
59	11	2	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Credit Mgr.
11. Industry or business

FATHER
12. Name Edward A. Crowder
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lula May Wright
15. Birthplace Petersburg, Va.

16 (a) Informant Mr. Orville W. Crowder
(b) Address 2910 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 12 1947 (Date received by registrar) (b) Certificate by Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10/47 19 , at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 12/11/47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 057889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 E. 22nd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Gilmore CHARLES DAVIS WALLACE GILMORE

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rosa P. Gilmore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 19, 1876

8. AGE: Years 71 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation: Accountant

11. Industry or business: P. R. R.

FATHER
12. Name: Joseph C. B. Gilmore
13. Birthplace: Md.

MOTHER
14. Maiden Name: Rebecca Harris
15. Birthplace: Md.

16 (a) Informant: Mrs. Rosa P. Gilmore
(b) Address: 218 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 12 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10/47 19 at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Vascular Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.

Date signed 12/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 057890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 W. 37th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MR. CHARLES TERPANY

3 (b) If veteran, name war: -

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mable B. (nee Baltzer)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1881

8. AGE: Years	Months	Days	If less than one day
66	0	18	hr. min.

9. Birthplace Marion, Ohio (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Western Union

FATHER
12. Name Charles Terpany
13. Birthplace Ohio

MOTHER
14. Maiden Name Elizabeth Zook
15. Birthplace Ohio

16 (a) Informant Mrs. Kathryn E. Ballman
(b) Address 1334 W. 37th St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/12/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 12 1947 (Date rec'd by registrar) Hattie [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1947, at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1947, to 12-9 1947, and that I last saw him alive on 12-9-1947.

Immediate cause of death	Duration
Recent anterior and Postero Myocardial Infarction.	
Due to Coronary artery sclerosis and thrombosis.	
Due to	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan Y. Lovlinsky M. D.
Address Sinai Hospital Date signed 12-10-47

G57891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G57891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Ensor St.
(c) Hospital or institution: 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Ensor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Citro

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Palmerino H. Citro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 31 1880

8. AGE: Years	Months	Days	If less than one day
67	4	11	hr. min.

9. Birthplace ATRIPALDA Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name GIOVANNI DEL GIUDICE
13. Birthplace Italy

MOTHER
14. Maiden Name FILOMENA FARINA
15. Birthplace Italy

16 (a) Informant Louis S. Citro (Son)
(b) Address 1823 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15 1947 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Germanhill Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) DEC 12 1947 (Date received by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1947, at 11:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1947, to Dec 10 1947 and that I last saw h[illegible] alive on Dec 10 1947

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Scognotti M. D.
Address 1729 W Lombard St. Date signed 12/12/47

G57892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/61

Registered No. G57892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State M.D. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 S. ANN ST. #31 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ANNA [redacted] RUKOWICZ (KALINOWSKI)

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-05-0791

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife ALEXANDER RUKOWICZ
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 10, 1892

8. AGE: Years	Months	Days	If less than one day
55	7	1	hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name Konstanty Kalinowski
13. Birthplace Poland

MOTHER
14. Maiden Name Jozefa Rybarczyk
15. Birthplace Poland

16 (a) Informant Alexander Rukowicz
(b) Address 513 S. Ann st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-47 (month) (day) (year)
(c) Cemetery or [redacted] St Stanislaus
Location Baltimore md

18 (a) Funeral director George R Weber
(b) Address 705 S Ann st

DEC 12 1947 (Date rec'd by Registrar) Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1947, at 1 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1947, to 12/11 1947, and that I last saw h.E.R. alive on 12/11 1947

Immediate cause of death CEREBRAL HEMORRHAGE — Duration

Due to ARTERIOSCLEROSIS

Due to DIABETES MELLITUS

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry J. Hanaka M.D.
Address 1 E. Jos. St. Date signed 12/11/47

G57893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83 D

Registered No. G57893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 731 South Ann Street
(c) Hospital or institution: Home 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 731 South Ann Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexandra Lillian Baginski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~: Alexander Baginski

6 (c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.) May ? 1885 ?

8. AGE: Years: 62 ? | Months | Days | If less than one day: hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Podgorski
13. Birthplace Poland

MOTHER
14. Maiden Name Katherine ?
15. Birthplace ?

16 (a) Informant Mrs. Helen Sacker (Daughter)
(b) Address 531 South Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-47 (month) (day) (year)
(c) Cemetery ~~xxxxxxx~~ Holy Rosary
Location Baltimore County, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 DEC 12 1947 Clifton for Williams M.D.
(Date rec'd by registrar) (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11th 1947, at 12 00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947 to Dec. 11 1947, and that I last saw her alive on Dec. 11 1947

Immediate cause of death	Duration
Myocardial Insufficiency	24 hrs.
Due to Hemiplegia (Right)	4 days
Due to Arteriosclerosis & Hypertension	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Feyertick M. D.
Address 9802 Eastern Ave Date signed 12-11-47

X

57894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

Registered No. 052894

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 35 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Brown
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Mrs. Daniels
(b) Address 2334 N. Exeter St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Dec 11th 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Brooklandville Md

18 (a) Funeral director Elwood Wilson
(b) Address 1000 Brantley Rd Huntington Hillsboro, Md.

19 (a) DEC 12 1947 (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at 11.25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed skull
Rupture of heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 5-2

(a) Date of injury 12-8-47 at 11 P.M.
(b) Where did injury occur? Orleans at Colvin Sts. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by bus

23. Signature Emil Kyd M.D.
Medical Examiner
Date signed 12-9-47

G57895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G57895

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2614 E. Chase Street
(c) Hospital or institution: 83
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 E. Chase St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Levin Herbert Bryant

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna (nee Flippin)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1868

8. AGE: Years	Months	Days	If less than one day
79	8	17	hr. min.

9. Birthplace Lancaster County, Va. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Edward Bryant
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Anna Flippin Bryant
(b) Address 2614 E. Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave., Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-5-5 E. Madison Street

19 (a) Dated 12-12-1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

DEC 12 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1947 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Dec 11 1947 and that I last saw him alive on Dec 11 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	3 Days
Pulmonary Edema	
Due to Uremic Arteriosclerosis	5 yrs.
Due to Chronic Nephritis.	
Cardiac Cystitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. G. Jeffers M.D.
Address 17 W. Mulberry St. Date signed 12/14/47

657896

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194A

657896 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gilbert's Sanatorial Mt
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 93 Fifth Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Willard MORSE

3 (b) If veteran, name war

3 (c) Social Security Account No 055-09-5189

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Grace H.

6 (c) If alive, give age 5 years

7. Birth date of deceased (mo., day, yr.) July 12, 1879

8. AGE: Years	Months	Days	If less than one day
68	4	29	hr. min.

9. Birthplace Westchester County N.Y.
(Town, county, and state)

10. Usual Occupation Lady Secretary

11. Industry or business S. B. Fields Co

FATHER 12. Name Jerome E Morse ?
13. Birthplace Texas ?

MOTHER 14. Maiden Name Ella Packard ?
15. Birthplace New York ?

16 (a) Informant George Carlos Attwood
(b) Address 60 Fenwick St N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (month) (day) (year)

(c) Cemetery or crematory Kensico
Location Kensico New York

18 (a) Funeral director F. B. Stippelt Sons
(b) Address 300 Eastern Place

19 (a) DEC 13 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 / 11 / 1947 at 9.00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/12/47

G57897 Inc 49577 115680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 D

Registered No. G57897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Ward (Mildred

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 5th 1947

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Ward
13. Birthplace ?

MOTHER
14. Maiden Name Mildred Washington
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 12-10-47 (month) (day) (year)
(c) Crematory Balto City Hosp
Location 4940 Eastern Ave

18 (a) Funeral director Balto City Hosp
(b) Address Records

19 (a) DEC 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P M

20. DATE OF DEATH December 8th 1947 at 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5th 1947, to Dec. 8th 1947, and that I last saw h er alive on Dec. 8th 1947.

Immediate cause of death	Duration
Respiratory Failure	1 day
Due to Ruptured Encephalocele	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ruptured Encephaloceles

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosps. Date signed 11 Dec 47

X

G57898 B.C. M-93594 TN. 114957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77 V 159

Registered No. G57898

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 5 7 6 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 Dillon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Anderson (Mary Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3rd. 1947

8. AGE: Years	Months	Days	If less than one day
	1	5	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Mary Ruth Anderson
15. Birthplace S. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Cremated (b) Date thereof 12-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery or~~ crematory Balto City Hosp
Location 4940 Eastern Ave

18 (a) ~~Funeral director~~ Balto City Hosp
(b) ~~Address~~ Records

19 DEC 13 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A. M

20. DATE OF DEATH December 8th. 1947, at 10.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3rd 1947, to Dec. 8 1947, and that I last saw h er alive on Dec. 8th 1947.

Immediate cause of death Premature

	Duration
	36

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Premature

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald H Baker M. D.

Address Balto City Hosp Date signed 12/10/47

VS 150

057899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 54a

Registered No. 057899

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted] 901 E Monument
(c) Hospital or institution: Sanai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Anne Arundel
(c) City or town Baltimore MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5020 Brookwood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donna Lee Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1946

8. AGE: Years | Months: 20 | Days | If less than one day: hr. min.

9. Birthplace Portland Maine (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Walter Smith
13. Birthplace 5020 Brookwood Rd

MOTHER
14. Maiden Name Dorothy Frange
15. Birthplace Portland Maine

16 (a) Informant Mr Walter Smith
(b) Address 5020 Brookwood Rd

17 (a) Holy Cross (b) Date thereof (Burial, cremation, or removal) Dec 13-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Gr Rockville Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 Harford St

19 (a) Dec 13 1947 (Date rec'd by Registrar) Undertaking for Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1947, at 1 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1947, to 12/10 1947 and that I last saw he alive on 12/10 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Brain Tumor	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Brain Tumor

of autopsy: ↗

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E.O. Goldstein M. D.
Address Sinai Hospital Date signed 12/10

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G57900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Genl Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Calloway Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Thomas Greene

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Elsie S. Greene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1878

8. AGE: Years	Months	Days	If less than one day
68	11	14	hr. min.

9. Birthplace Covington, Kentucky
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Crown Central Petroleum Corp.

FATHER
12. Name George H. Greene
13. Birthplace Unknown

MOTHER
14. Maiden Name -- Harris
15. Birthplace Unknown

16 (a) Informant Mrs. Elsie S. Greene wife
(b) Address 3404 Calloway Ave.

17 (a) Entombment (b) Date thereof 12/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 13 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1947, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kelly M.D.
Medical Examiner.
Date signed Dec 12, 1947

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 657901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere Hotel Charles
Brooklawn (If institution, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE WOLFE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	217-14-5271

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	single

6 (b) Name of husband or wife 00
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1882

8. AGE: Years	Months	Days	If less than one day
65	6	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Marine Engineer
11. Industry or business

FATHER
12. Name Lawrence Wolfe
13. Birthplace Harrisburg, Pa.

MOTHER
14. Maiden Name Annie Ryan
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Blanche Ireton
(b) Address 424 E. 25th St.

17 (a) Burial (b) Date thereof 12/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12/47 19, at 1:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Sauer, M.D.
Medical Examiner.
Date signed 12/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

157902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. 157902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge (If outside city or town limits, write RURAL and give town)
(d) Street No. 5800 Old Wash Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES EDWARD TOOMEY, Sr.

3 (b) If veteran, name war: WW
3 (c) Social Security Account No.: Unk.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Grace A. Toomey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 6, 1874

8. AGE: Years	Months	Days	If less than one day
73	1	5	hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Building & Fuels

FATHER
12. Name: Joseph Henry Toomey
13. Birthplace: Md.

MOTHER
14. Maiden Name: Christina Cürspring
15. Birthplace: Balto. Co.

16 (a) Informant: Mr. Charles E. Toomey, Jr.
(b) Address: 5804 Old Wash. Rd., Elkridge

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 13 1947 (Date rec'd by the Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11/1947, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12/1947 to 12/11/1947, and that I last saw h/ alive on 12/11/1947

Immediate cause of death	Duration
pulmonary edema	3 wks
Due to periarteritis nodosum	2
Due to	
Other Conditions multiple cerebral infarctions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Doerr, M. D.
Address University Hosp. Date signed 12/13/47

VS 190

99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 93D

Registered No. 057903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (12)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Druid Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Joseph Brooks

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jean Hay Brooks
(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) June 27, 1876

8. AGE: Years 71 | Months 5 | Days 14 | If less than one day — hr. — min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Teacher Retired

11. Industry or business U. S. Govt.

FATHER 12. Name Joseph T. Brooks

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Elizabeth Talken

15. Birthplace Maryland

16 (a) Informant

(b) Address Wife

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (month) (day) (year)

(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) DEC 13 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11-47 19..., at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1947 to Dec. 11 1947, and that I last saw h.alive on 12-11 1947

Immediate cause of death Urgemia
terminal bronchio-pneumonia

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Benign prostatic hypertrophy

(Significant conditions within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James McC. Finney M. D.

Address Union Memorial Hosp Date signed 12-11-47

VS 150

657904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

657904 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 Laurens St.
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY JAMES GREB

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Annie M. Greb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1887

8. AGE: Years	Months	Days	If less than one day
60	2	17	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Storekeeper - self
11. Industry or business

FATHER
12. Name August Greb
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Weidner
15. Birthplace Germany

16 (a) Informant Mrs. Annie M. Greb
(b) Address 618 Laurens St.

17 (a) Burial (b) Date thereof 12/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) DEC 13 1947 (b) Evelyn Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1947, at 8:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1947, to Dec 11 1947, and that I last saw h[illegible] alive on Dec 11 1947.

Immediate cause of death	Duration
Cerebral Hemorrage	12/10/47
Due to Chr. myocarditis	1947
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul E. Bowie M. D.
Address 1663 W North Ave. Date signed 12/12/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

Registered No. G57905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills (If outside city or town limits, write RURAL and give town)
(d) Street No. Pleasant Hill Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: BESSIE LAUGHLIN RITCHEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Michael W. Ritchey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1872

8. AGE: Years 75 | Months 2 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas J. Laughkin
13. Birthplace County Antrim, Ireland

MOTHER
14. Maiden Name Rachel Wylie
15. Birthplace Ireland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 13 1947 (Date rec'd by registrar) (b) [illegible] M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1947, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4th 1947 to Dec. 10th 1947. and that I last saw h er alive on Dec. 10th 1947.

Immediate cause of death	Duration
Chronic Myocarditis	2 yrs.
Due to Art. Sclerosis	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Pikesville, Md. Date signed 12/12/47

X

G57906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G57906

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5904 Washington Ave.
(c) Hospital or institution: 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5904 Washington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH A. FLETCHER

3 (b) If veteran, name war --

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife B. Wheatley Fletcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1867

8. AGE: Years	Months	Days	If less than one day
79	11	15	hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER
12. Name Henry C. Amoss
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Frazer
15. Birthplace Dorchester Co., Md.

16 (a) Informant Mrs. H. E. Thrift
(b) Address 4009 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 13 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1947, at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1947, to 12/10 1947, and that I last saw her alive on 12/10 1947.

Immediate cause of death Coronary Occlusion — Duration
Due to Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address 12 E Saratoga St Date signed 12/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. 052907

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 827 RUTLAND AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 RUTLAND AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVELYN PAYTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race C.

6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife ANDREW

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1897

8. AGE: Years 50 | Months ✓ | Days 14 | If less than one day hr. min.

9. Birthplace Dorchester Cty., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John ENNALS
13. Birthplace Md.

MOTHER 14. Maiden Name MARY Hooper
15. Birthplace Md.

16 (a) Informant ANDREW PAYTON
(b) Address 827 RUTLAND AVE.

17 (a) BURIAL (b) Date thereof 12-14-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. CALVARY
Location A.A. County, Md

18 (a) Funeral director Joseph L. Locke
(b) Address 0, 3644 N. Central Ave

19 (a) 12 13 1947 (Date rec'd by registrar) (b) Huntingtown, Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1947 at 6 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1947 to Dec 10 1947, and that I last saw h alive on Dec 10 1947

Immediate cause of death Cerebral Hemorrhage — Duration 3 days
a (Rt) Hemiplegia
Due to Extreme Hypertension
Due to Arteria Sclerosis
Other Conditions Mitral Insufficiency

(Include pregnancy within 3 months of death)
Date of operation Unknown
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ralph E Young M. D.
Address 429 E Monument St Date signed 12/11/47

VS 150

83 A

C57908

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C57908

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway.
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick.
(c) City or town Frederick Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 503 W 2nd St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Ruth Martz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30, 1899

8. AGE: Years	Months	Days	If less than one day
48	0	14	....hr. ....min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Social worker
11. Industry or business Social worker.

FATHER
12. Name John Martz
13. Birthplace Frederick Md

MOTHER
14. Maiden Name Mary Mcomty
15. Birthplace Frederick

16 (a) Informant Sister (Miss Helen Martz) R.N.
(b) Address Church Home & Hosp.

17 (a) Burial (b) Date thereof 12/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Md

18 (a) Funeral director M R Etchison Son
(b) Address Frederick Md

19 (a) DEC 13 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1947, at 12½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1947 to 12/13 1947 and that I last saw h.m. alive on 12/12/1947.

Cause of death	Duration
Immediate cause of death Encephalopathy	
due to antecedent hypertension	2 hrs.
Due to hypertension and chronic nephritis	15 yrs.
Due to	
Other Conditions One kidney (TB) previously removed. (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Bachrach M. D.
Address Church Home & Hosp. Date signed 12/13/47

VS 150

057909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1936

Registered No. 057909

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 S Curley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Frank F. Altmann.

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-09-8025

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married.

6 (b) Name of husband or wife Viola A. Altmann (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1-1908.

8. AGE: Years	Months	Days	If less than one day
39	0	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Machinist.
11. Industry or business Beth. Steel Co.

FATHER
12. Name Joseph Altmann.
13. Birthplace Austria.

MOTHER
14. Maiden Name Josephine Svacek.
15. Birthplace Bohemia.

16 (a) Informant Mrs. Viola A. Altmann.
(b) Address 201-S. McCurley St.

17 (a) Burial (b) Date thereof Dec. 15/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 3512 Frederick Ave.

19 (a) DEC 12 1947 (b) Martin for Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1947 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 19__, to 12/11 1947 and that I last saw h__ alive on 12/1 1947

Immediate cause of death Cardiac failure - Hypertension C.V.D.

Due to Severe Glom. Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 12/12/47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... supplied. The correct age is especially important. Physicians: please write the ... the causes of death clearly and legibly.

$57910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 57910

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (~~years~~, or days) 22
(e) Length of stay in Baltimore (~~years~~, or days) 22

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Fountain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Madaline Fountain
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Nov. 8 1904

8. AGE: Years	Months	Days	If less than one day
43	1	5	...hr. ...min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Fertilizer Foreman
11. Industry or business

FATHER
12. Name Hugh Fountain
13. Birthplace Maryland

MOTHER
14. Maiden Name Nettie Snow
15. Birthplace Md.

16 (a) Informant Mrs. Madaline Fountain
(b) Address Cambridge, Md.

17 (a) Burial (b) Date thereof Dec 15 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cambridge Cem.
Location Cambridge, Md.

18 (a) Funeral director John O. Mitchell Funl
(b) Address 409 Race

19 (a) DEC 13 1947 (b) Hunting for Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1947 to 12/13 1947 and that I last saw him alive on 12/15 1947

Immediate cause of death Hemorrhage — Duration 1 mo.

Due to Carcinoma of Stomach

Due to

Other Conditions Metastases - Local -
(Include pregnancy within 3 months of death)

Date of operation 2 Dec. 1947

Major findings of operation: diffuse malignant Carcinoma of Stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ...at... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. K. Morrow M. D.
Address Church Home & Hosp. Date signed 12/13 47

VS 150

657911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

657911 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5811 Remmel Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Goetze

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	212-01-6768

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Nellie M. Goetze
6 (c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1862

8. AGE: Years	Months	Days	If less than one day
85	0	4	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business Levin Furniture Co.

FATHER
12. Name Henry Goetze
13. Birthplace Maryland

MOTHER
14. Maiden Name Katherine Bohnet
15. Birthplace Maryland

16 (a) Informant Mrs. Nellie M. Goetze
(b) Address 5811 Remmel Avenue

17 (a) Burial (b) Date thereof 12/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 13 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 1947, at 6:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1947 to 12/12 1947 and that I last saw h[illegible] alive on 12/12 1947.

Immediate cause of death	Duration
Probable cerebral embolism	
Due to Acute myocardial infarction	7 days
Due to Coronary sclerosis & sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Phillips M. D.
Address [illegible] Date signed 12/12/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57912
444291

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93A

Registered No. G57912

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town Towson. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Ensor, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alventa Bertha Hinton
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: James Hinton
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 9-18-91

8. AGE: Years 56 | Months 2 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation housf
11. Industry or business

FATHER 12. Name Joshua Winder
FATHER 13. Birthplace Md.
MOTHER 14. Maiden Name ?
MOTHER 15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ... (b) Date thereof 12-14-1947 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Pleasant Rest
Location Towson Md.

18 (a) Funeral director Bafrow Inman & Wright
(b) Address 721 Cathedral St

19 (a) ... (Signature of local registrar) Registrar

DEC 13 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 - 1947 at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29- 1947 to 12-11- 1947 and that I last saw her alive on 12-11- 1947.

Immediate cause of death: CEREBRAL HEMORRHAGE — Duration: 2 weeks
Due to: Hypertension — Duration: several years
Due to: —
Other Conditions: gastrointestinal bleeding — Duration: 4 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas E. Van Metre M.D.
Address Johns Hopkins Hosp. Date signed 12/11/47

G57913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

Registered No. G57913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution:
PROVIDENT
(d) Length of stay in hospital or inst. (yrs., mos., or days) 81 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 532 Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Murdock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FE

5. Color or race: N

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/28/90

8. AGE: Years 57 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Ofsm Carter
13. Birthplace Montgomery Co Md

MOTHER
14. Maiden Name Judy Carter
15. Birthplace Montgomery Co Md

16 (a) Informant Rosella Murdock
(b) Address 532 N. Hoffman St

17 (a) Burial (b) Date thereof 12-14-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fort Calvary Cem.
Location Brookroad Md

18 (a) Funeral director George W. Gilpin
(b) Address 1735 Druid Hill Ave

19 DEC 13 1947 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1947, at 7 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1947 to 12/10 1947, and that I last saw h.e.r alive on 12/10 1947

	Duration
Immediate cause of death Uremia	
Due to Hypertensive C.V. Renal Disease	81 dys.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carter Hart M.D.
Address 514 Division Date signed 12/11/47

VS 150

657914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83 A

Registered No. 657914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7614 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 78yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7614 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred Albert Schrade

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-8379

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ethel B. Schrade

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31st 1868

8. AGE: Years 79 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Adams Co. Pa. (Town, county and state)

10. Usual Occupation retired - Blacksmith

11. Industry or business

FATHER 12. Name John Schrade

13. Birthplace Germany

MOTHER 14. Maiden Name Miss Holtz

15. Birthplace Germany

16 (a) Informant Mrs. Ethel B. Schrade

(b) Address 7614 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15th 1947 (month) (day) (year)

(c) Cemetery or crematory London Park Cem.

Location 3801 Edmondson Ave. Balto Md

18 (a) Funeral director E. Kelly Lamograux

(b) Address 4510 Liberty Heights Ave

19 DEC 13 1947 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11th 1947, at 9 3/4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5 1947 to 12-11 1947, and that I last saw h. alive on 12-11 1947.

Immediate cause of death Bronchopneumonia — Duration 1 da

Due to Cerebral Hemorrhage — Duration 12/5/47

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph H. Lacy (attn)

Address 679 Washington Blvd Date signed 12/16/47

657915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49 A

Registered No. 657915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Mayland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Turnbridge Rd #12
(If rural give location)
(e) Citizen of foreign country? (~~Yes~~ or No)
If yes, name country

3 (a) FULL NAME Mary E. Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1878

8. AGE: Years	Months	Days	If less than one day
69	2	22	hr. min.

9. Birthplace Florida Pensacola
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Matthew Jackson
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ewing
15. Birthplace Ireland

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 12/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Philadelphia, Pa.

18 (a) Funeral director Wm. J. Tickner + Sons
(b) Address No. 8 Pa. Ave. Balto. 12 Md.

19 (a) Date received by (Registrar) Huntington Williams M.D. Registrar
DEC 15 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1947, at 11:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1947 to 12/13 1947, and that I last saw her alive on 12/13 1947

Immediate cause of death	Duration
respiratory failure due probably to ruptured	
Due to ruptured uterus due to	
Due to Carcinomatosis of abdominal cavity	
Other Conditions due to malignant ovary (Cystadenoma-malignant)	

(Include pregnancy within 3 months of death)

Date of operation one year previously

Major findings of operation: extensive carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Mitchell M. D.

Address Md Gen Hosp Date signed 12/19/47

G57916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G57916 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Liberty St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lydia A. Troxtle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: White | 5. Color or race: Female | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12 1867

8. AGE: Years 80 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Adams Co Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Troxtle
13. Birthplace Pa.

MOTHER 14. Maiden Name Elizabeth Pfoutz
15. Birthplace Pa

16 (a) Informant Mrs John Theigh
(b) Address 115 Liberty St Westminster

17 (a) Burial (b) Date thereof Dec 16 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Branch
Location Carroll Co.

18 (a) Funeral director H Bankard & Sons
(b) Address Westminster Md.

19 (a) DEC 1947 (b) Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Dec. 1947, at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchio-pneumonia, bilateral.

Due to Hypostasis from bed rest due comminuted fracture, rt. femur

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/12 at 9 a M.
(b) Where did injury occur? 115 - Liberty St Res
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Slipped & fell

23. Signature Wm. H. Rahmer Jr. M.D.
Medical Examiner.
Date signed 12 Dec. 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57917 X G57917

G57917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. Bird R (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Taeuber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Audrey Taeuber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17, 1896

8. AGE: Years 51 | Months | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Real Hayden Co

11. Industry or business

FATHER
12. Name Charles Taeuber
13. Birthplace Balto

MOTHER
14. Maiden Name Sauers
15. Birthplace Balto

16 (a) Informant wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 16 47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Md.

18 (a) Funeral director Lauchheimer Funeral Home
(b) Address 7401 Belair Rd.

19 (a) DEC 19 1947 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1947, at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947, to Dec 12 1947, and that I last saw him alive on Dec 12 1947.

Immediate cause of death	Duration
Myocardial infarction	11 days
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: confirming dx

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Hall M. D.
Address South Balto Gen. Date signed 12/12

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LW G57918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G57918 / 107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Sipple Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles E. Diver or Charles E. Divers ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6- 1874

8. AGE: Years 73 | Months | Days ? | If less than one day ____hr. ____min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William A. Diver
13. Birthplace Md.

MOTHER 14. Maiden Name Mary
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 16 47 (month) (day) (year)
(c) Cemetery or crematory Oakland Lawn
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 4704 Belair Rd.

DEC 14 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13- 1947, at 8:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10- 1947 to 12-13- 1947 and that I last saw h im alive on 12-13- 1947

Immediate cause of death: Subdural Hematoma — Duration 2½ days
Due to:
Due to:
Other Conditions: Probable Bronchopneumonia — 1 day
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy: Same (limited to head)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 12-13-47

VS 150

83A

G57919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G57919 Registered No.

FILL IN EVERY ITEM OF INFORMATION should be carefully supplied. The effect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 N. Bentalou St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 N. Bentalou st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1891

8. AGE: Years 56 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Clothing Business

FATHER 12. Name Meyer Cohen
13. Birthplace Russia

MOTHER 14. Maiden Name Anna Moderick
15. Birthplace Russia

16 (a) Informant Miss Rita Cohen
(b) Address 1912 N Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14/47 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern ave

18 (a) Funeral director Sol Levinson + Bros
(b) Address 1134 W. North ave

19 (a) [illegible] (b) [illegible]
(Rec'd by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1946 to 12-13 1947, and that I last saw h. alive on 12-13 1947.

Immediate cause of death: Coronary occlusion — Duration: ?

Due to: Hypertension — ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Levinson M. D.
Address [illegible] Date signed 12-13-47

657920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55C

657920 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BELVEDERE & GREENSPRING AVE.
(c) Hospital or institution: LEVINDALE HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5003 QUEENSBURY AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HYMAN STEIN

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-18-9761

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ROSE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
44	-	-	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business ADV. BUSINESS

FATHER
12. Name MORRIS S TEIN
13. Birthplace ROSSIA

MOTHER
14. Maiden Name LENA LEVINSON
15. Birthplace ROSSIA

16 (a) Informant ROSE STEIN
(b) Address 5003 QUEENSBURY AVE.

17 (a) BURIAL (b) Date thereof 12 14 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BETH ISRAEL
Location BOWLEYS LANE - HERRING RUN

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1124-26 W. NORTH AVE.

19 (a) DEC 14 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 13 1947, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1947 to 12-13 1947 and that I last saw him alive on 12-13 1947

Immediate cause of death Carcinoma of thyroid with metastases to brain & left lung — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 12-13-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 466

G57921 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3314 FALLSTAFF ROAD
(c) Hospital or institution: 73
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 S. CHARLES ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID HEYMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife LATE MOLLIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace ROSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business NONE

FATHER
12. Name AARON HEYIMAN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ROSSIA

16 (a) Informant MRS. HARRY SHOFER
(b) Address 3314 FALLSTAFF ROAD

17 (a) BURIAL (b) Date thereof 12 14 47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ANSHEI EMONAH
Location WASHINGTON BLVD

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1124-26 W NORTH AVE.

DEC 14 1947

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1947 at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7 1947 to 12/12 1947 and that I last saw him alive on 12/12 1947

Immediate cause of death

	Duration
Carcinoma of Pancreas	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kenneth J. Hanbon M. D.
Address 831 Eutaw Pl Date signed 12/12/47

Huntington Hill

G57922 — BALTIMORE CITY HEALTH DEPARTMENT — G57922

CERTIFICATE OF DEATH 1930

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3648 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3648 Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Kline Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of decessed (mo., day, yr.) Sept 10-1875

8. AGE: Years	Months	Days	If less than one day
72	- 3	- 2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Wm H. Kline Sr.
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Virgie L. Stone
(b) Address 3648 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Frederick Ave (Baltimore)

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St

(c) Filed DEC 3 1947 (Date registered) Huntington Williams, M.D. (Local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1947 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1 1944 to Dec 12 1947, and that I last saw him alive on Dec 1 1947.

Immediate cause of death: Heart failure due to Hypostatic pneumonia
Due to Cardio-vascular disease
Due to
Other Conditions arthritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Ruth M. D.
Address 203 Bulfinch Date signed

VS 150

G57923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G57923 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 S. Monroe st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna R. Mahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 1868

8. AGE: Years	Months	Days	If less than one day
79	2	8	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Gottlieb Mahn
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Mahn
15. Birthplace Germany

16 (a) Informant Geo. H. Clatterbuck
(b) Address 124 S. Monroe St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/15/47 (month) (day) (year)
(c) Cemetery ~~or Crematory~~ St. John's
Location Ellicott City Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Dec. 1947 at 9A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer Jr. M.D.
Medical Examiner.
Date signed 13 Dec. 1947

VS 151

G57924 — BALTIMORE CITY HEALTH DEPARTMENT — G57924

CERTIFICATE OF DEATH

Registered No. ✓ 46 A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Deepdene Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Deepdene Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice E Turnbull

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 215-10-1096
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna E
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 18, 1880
8. AGE: Years 67 | Months 10 | Days 2420 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business H. C. Compton & Co

FATHER
12. Name John Turnbull
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Rose Herring
15. Birthplace Baltimore Md

16 (a) Informant Anna E Turnbull
(b) Address 703 Deepdene Rd
17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md
18 (a) Funeral director Wilbur Cook Inc
(b) Address 1217 St Paul St
19 (a) (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

Obits 458

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1947 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1947 to Dec 11 1947, and that I last saw him alive on Dec 11 1947.

Immediate cause of death: Pulmonary Embolism — Duration: 1 hour
Due to: Progressive Carcinoma of the esophagus with metastasis to lung, right
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A Garlick M. D.
Address 2 West Road Date signed Dec 13, 1947

X Garlick

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G57925 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 N. Fulton Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie C. Hobbs

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Samuel A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1877

8. AGE: Years 70 | Months 3 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Senf
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Samuel A. Hobbs
(b) Address 205 N. Fulton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15-47 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Lorraine, Baltimore

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1947, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1947 to Dec. 11 1947 and that I last saw her alive on Dec. 11 1947

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Disease	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Horace Lamy Cohen M. D.
Address 400 N. Payson St. Date signed 12/12/47

657926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

657926 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 Brighton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Klein, Charles

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-12-9983

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Beatrice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1896

8. AGE: Years	Months	Days	If less than one day
51	4	28	hr. min.

9. Birthplace Balto. Md. (Town, county and state)
10. Usual Occupation Bread Wrapper
11. Industry or business Rice Bakery

FATHER
12. Name Henry C. Klein
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Dromph
15. Birthplace Germany

16 (a) Informant Beatrice Klein
(b) Address 3031 Brighton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) 1217 St. Paul St.
(c) (Date rec'd by registrar) (d) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12-47 19 , at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1947 to 12-11 1947 and that I last saw him alive on 12-12 1947

Immediate cause of death Syncope
Toxicity of Spin. Sensitivity
Due to Rectal Diverticulitis with Obstruction and Rupture.
Due to
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation 12-11-47
Major findings of operation: Rectal Mass, & Rupture
of autopsy: Rectal Diverticulitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B. Schmidt, M. D.
Address Franklin Sq. Hosp. Date signed 12-12-47

VS 150

G57927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 E

G57927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Okla (b) County
(c) City or town Tulsa
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1776 E. 31st. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Edwards

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-11-41

8. AGE: Years 6 | Months 6 | Days 2 | If less than one day ___ hr. ___ min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Dougald Edwards
13. Birthplace Texas

MOTHER 14. Maiden Name Katherine Smith
15. Birthplace Texas

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-14-47 (month) (day) (year)
(c) Cemetery or crematory TULSA
Location TULSA OKLAHOMA

18 (a) Funeral director Joby O Mitchell & Son
(b) Address 1820 E Eutaw Place

19 (a) DEC 1947 (Dept. records) (b) [illegible] Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1947 at 12 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1947 to Dec 13 1947 and that I last saw h[illegible]ive on Dec 13 1947

Immediate cause of death: Congenital Heart Disease — Duration: Life

Due to

Due to

Other Conditions Operation - Anastomosis Subclavian to Pulmonary Artery
(Include pregnancy within 3 months of death)

Date of operation 12-13-47

Major findings of operation:

of autopsy Single ventricle -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. Clay M. D.
Address Johns Hopkins Hosp Date signed 12-14-47

657928 BALTIMORE CITY HEALTH DEPARTMENT 657928

CERTIFICATE OF DEATH ✓ 178a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Bayne Ave
(c) Hospital or institution:
West Balto General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 N. Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myra E. Keesey.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W

6 (b) Name of husband or wife Robert W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14 1887

8. AGE: Years	Months	Days	If less than one day
60	0	29	hr. min.

9. Birthplace Highrock, Pa.
(Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name John T. Grove
13. Birthplace Pa

MOTHER
14. Maiden Name Agnes Wilson
15. Birthplace Pa

16 (a) Informant Harold Keesey
(b) Address 33 Old Annapolis Rd Linthicum

17 (a) Burial (b) Date thereof 12-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hopewell Luth. Church Cemetery
Location Severn, Md.

18 (a) Funeral director Lorenz Bros
(b) Address 500 Park Ave
(b) Waltersville Williams, M.D.

DEC 14 1947
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Dec 1947 at 11 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due carbon
monoxide poisoning
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/13/47 at 10 a M.
(b) Where did injury occur? 3808 W. Garrison Ave Balto Md
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas stove

23. Signature Wm. R. Jamming M.D.
Medical Examiner.
Date signed 13 Dec. 1947

VS 151

128

G57929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G57929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Violet Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Bloom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color: ~~White~~

6 (a) Single, married, widowed, or ~~divorced~~: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1911

8. AGE: Years 36 | Months 23 | Days 6 | If less than one day: hr. min.

9. Birthplace: Poland-Russia (Town, county, and state)

10. Usual Occupation: Auto Mechanic

11. Industry or business

FATHER
12. Name: Joel Bloom
13. Birthplace: Poland

MOTHER
14. Maiden Name: Jennie Lifschman
15. Birthplace: Poland

16 (a) Informant: Jack Bloom brother
(b) Address: 3226 Tioga Parkway Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-14-47 (month) (day) (year)
(c) Cemetery or crematory: United Hebrew
Location: Washington Boulevard

18 (a) Funeral director: Jos. Lewis Inc
(b) Address: 2160 Eutaw Place

19 (a) DEC 14 1947 (b) Date rec'd by registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-13 1947, at 9:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1947 to 12-13 1947, and that I last saw h-d alive on 12-13 1947.

Immediate cause of death: Acute coronary occlusion — Duration:
Due to: HCVD
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Sam M. Fox M.D.
M. D.
Address: Sinai Memorial Hosp Date signed 12/13

VS 180

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G57930 / 47D

Registered No. G57930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST & RUTLAND AVE.
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO. CITY
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 COLD SPRING LANE #5
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MEYER TRAUB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWER

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1874

8. AGE: Years	Months	Days	If less than one day
73	1	21	hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Doraly
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Sam Traub
(b) Address 3615 Gwynn Oak Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-47 (month) (day) (year)
(c) Cemetery or crematory Pikesville Memorial Park
Location

18 (a) Funeral director Jack Lentz Inc
(b) Address 2 Eastern Place

19 (a) (Date received by registrar) (b) Registrar

DEC 14 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 14 1947 at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 18, 1947 to DEC 14 1947, and that I last saw h/m alive on DEC 14, 1947.

Immediate cause of death	Duration
Cardio-respiratory failure	
Asphyxia	
Due to Pleural effusion, left	
Due to CA of Uterus	
Other Conditions Arteriosclerotic CVD	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac M. Lesshower M. D.
Address Sinai Hospital Date signed 12-14-47

X

G57931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G57931 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2710 Garrison Boulevard
(c) Hospital or institution:
15 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Garrison Boulevard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie P. Staylor

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or ~~wife~~ Thomas W. Staylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1871

8. AGE: Years	Months	Days	If less than one day
76	5	11	hr. min.

9. Birthplace Manassas, Va.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Patrick O'Donnell
13. Birthplace Va.

MOTHER
14. Maiden Name Ella Foley
15. Birthplace Va.

16 (a) Informant Mrs. Virginia M. Mead
(b) Address 2710 Garrison Boulevard

17 (a) Burial (b) Date thereof 12-15-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) Date DEC 14 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 2.10

20. DATE OF DEATH December 12, 1947, at p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 12 1947 and that I last saw h~~im~~ alive on Dec 12 1947

Immediate cause of death	Duration about 1 mo.
Myocarditis	
Due to arterio-sclerosis	7
Due to	
Other Conditions Secondary anemia	2

(Include pregnancy within 3 months of death)
Date of ~~operation~~
Major ~~findings of operation~~:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If ~~death was due to external causes~~, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did ~~injury occur about home~~, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Hallie Daublett M. D.
Address 2220 Harrison Blvd Date signed Dec. 13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 32B

G57932
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3306 Rosekemp Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Rosekemp Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Slater Jr

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/2/1895

8. AGE: Years	Months	Days	If less than one day
52	7	10	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Wm Slater
13. Birthplace Balto

MOTHER
14. Maiden Name Mary J Connolly
15. Birthplace Balto

16 (a) Informant Mrs Jos Slater
(b) Address 3306 Rosekemp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Ved Frederick Rd

18 (a) Funeral director D J Foley Sons
(b) Address 1 S Lighter St.

DEC 14 1947
(Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1947 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1943 to Dec 12 1947 and that I last saw h IM alive on Dec 11 1947.

Immediate cause of death	Duration
Carcinoma of Bladder	4 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Dawson M.D.
Address 4808 Harford Rd. Date signed 12/12/47

G57933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

3557933 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 56 Club Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Club Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Williams Jr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15 1871

8. AGE: Years	Months	Days	If less than one day
76	8	27	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Steam Ship Executive

FATHER
12. Name Henry Williams
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Georgeanna Deems
15. Birthplace Balto Md

16 (a) Informant Elizabeth C Williams
(b) Address 5 6 Club Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Balto Md

18 (a) Funeral director Henry W Hopkins & Son
(b) Address McCulloh & Dolphin Sts Huntington Williams, Md

19 (a) (Date rec'd by Registrar) (b) Registrar

DEC 14 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1947, at 4:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1947 to Dec 12 1947 and that I last saw him alive on Dec 12 1947

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to Arteriosclerotic Heart disease	2
Due to Generalized Arteriosclerosis	9
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Lord M. D.
Address 8 Longwood Rd. #10 Date signed Dec 12, 47

G57934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 A

G57934 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Maisel Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 77y 5mo 23days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Maisel Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Amelia Seebold

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Henry Adolf Seebold deceased. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June-20-1870

8. AGE: Years 77 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name August Myers
13. Birthplace unknown

MOTHER 14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Henry Seebold
(b) Address 2101 Maisel Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/47 (month) (day) (year)
(c) Cemetery or crematory Westview
Location Edmondson Ave

18 (a) Funeral director Edward Lowlace
(b) Address 2359 Reed Blvd

19 (a) [illegible] (Date received) registrar Huntington Williams

DEC 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH December-13 1947 at 11 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Dec-13 1947, and that I last saw h alive on December-10-1947

Immediate cause of death: Acute heart failure — Duration:
Due to: Cardio-Vascular-renal disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walther H. Sonnenfeldt M. D.
Address 4708 Hollins Ferry Road Date signed 12/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G57935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Cavendish Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Selbin S. Sherman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva E. Sherman

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.) 5-17-87

8. AGE: Years: 60 | Months: 6 | Days: 25 | If less than one day: hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Receiving Clerk

11. Industry or business

FATHER 12. Name William Sherman
13. Birthplace Maryland

MOTHER 14. Maiden Name Rachel Price
15. Birthplace Maryland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Cazall Co

18 (a) Funeral director Cheniquette & Donovan
(b) Address 3615-17 Greenmount Ave.

19 (a) DEC 15 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1947, at 12 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27 1947 to Dec. 12 1947, and that I last saw him alive on Dec. 12 1947.

	Duration
Immediate cause of death: Cerebro-vascular accident, with	46d.
Due to: mid-brain hemorrhage	
Due to: Arterio sclerosis	?yrs.
Other Conditions	

(Include pregnancy within three months of death)

Date of operation 25 Oct 47

Major findings of operation: hemorrhoids

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Hagino M.D.
Address Johns Hopkins Hosp. Date signed 12 Dec 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

657936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

657936
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1429 Northgate Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Northgate Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME M. Addie Gough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife David W. Gough

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1867

8. AGE: Years 80 Months 8 Days 7 If less than one day hr. min.

9. Birthplace Deale Island, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Hiram D. Tankersley
13. Birthplace Virginia

MOTHER
14. Maiden Name Judith Ann Shores
15. Birthplace Chance, Md.

16 (a) Informant Mrs Rose E. Collier
(b) Address 1429 Northgate Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Forrgine Park
Location Franklintown, Md

18 (a) Funeral director Roland E. Fisher
(b) Address 2112 Pennsylvania Ave. Baltimore, Md

19 (a) 1947 (Signature of registrar) (b) Registered [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1947, at 11.20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Dec 12 1947, and that I last saw h[illegible] alive on Dec 12 1947,

Immediate cause of death	Duration
Acute Uremia	3 days
" Cardiac Oil.	
Due to Hypertensive Heart Disease	4 yrs.
Due to Carcinoma of Breast	3 mos.
Other Conditions Metastases.	

(Important conditions within 3 months of death)

Date of operation Dec 5 1947

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. N. Mezick M. D.
Address 150 E. 32nd. Date signed Dec 14 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57937
327956

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52B

Registered No. G57937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27-14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Roland Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Upland Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alice M. Voss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-20-74

8. AGE: Years 73 | Months 4 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Wisc.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Kaison
13. Birthplace Sweden ?

MOTHER
14. Maiden Name Minnie Wilhin
15. Birthplace Sweden ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16 1947 (month) (day) (year)
(c) Cemetery or crematory St. James
Location Ruxton, Md.

18 (a) Funeral director Landon M. Brooks
(b) Address Govk md

19 DEC 15 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 - 1947 at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9- 1947 to 12-14-1947, and that I last saw h[er] alive on 12-14-1947

Immediate cause of death (1) Carcinoma of bladder, primary
secondary to chronic prostatitis
(2) Carcinoma of bladder, primary
Due to hydronephrosis & ureteral obstruction
(3) Diabetes mellitus
Due to (4) Arteriosclerosis, generalized
(5) Arthritis, hypertrophic
Other Conditions (6) ? Cerebral arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman E. Sherman M. D.
Address Johns Hopkins Hospital Date signed 12/14/47

G57938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57938
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 65
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) V-Army

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Filbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Mrs. Phyllis Czechanski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mr. John Czechanski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/4/[illegible]97

8. AGE: Years 50 (47) | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Gor Rotchild Hwy.

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St

19 (a) DEC 15 1947 (Date received by registrar) (b) Harrington Williams, M.D. Registrar

V8 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1947 at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1947 to 12/14 1947 and that I last saw h.e alive on 12/13 1947

Immediate cause of death Terminal coronary thrombosis

Due to Cardiac failure

Due to Hypertensive cardiovascular disease.

Other Conditions Cerebral vascular accident. Also uremia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul D. Manning M. D.
Address Bon Secours Hosp. Date signed 12/14/47

657939 Copy

657939
350344

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

Registered No. 657939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 N. DUNCAN, ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Siart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-14-72

8. AGE: Years	Months	Days	If less than one day
75	8	28	hr. min.

9. Birthplace Md. (Town, county and state)
10. Usual Occupation housework
11. Industry or business

FATHER
12. Name Charles Velenovsky
13. Birthplace Austria

MOTHER
14. Maiden Name Barbara Klima
15. Birthplace Austria

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-47 (month) (day) (year)
(c) Cemetery or crematory U. S. NATIONAL
Location Frederick Road, Balto.

18 (a) Funeral director Thos. Lyderson
(b) Address 900 N. Eutaw St.

19 DEC 15 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1947 at 4 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24- 1947 to 12-12- 1947 and that I last saw her alive on 12-12- 1947

Immediate cause of death	Duration
Hepatic coma	1wk
Due to Laennec's cirrhosis	yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: small granular liver & fatty
of autopsy: hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Bisson M. D.
Address Johns Hopkins Hosp. Date signed 12 Dec. 47

VS 150

657940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 657940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 N Smallwood St
(c) Hospital or institution: 154
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 N Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Block

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: House Wife

FATHER
12. Name: Michael Grinker
13. Birthplace: Russia

MOTHER
14. Maiden Name: Dena ?
15. Birthplace: Russia

16 (a) Informant: Louis Block
(b) Address: 2117 N Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 15, 1947 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Herring Run Cem
Location: Bowleys Lane

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) DEC 15 1941 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 12.30

20. DATE OF DEATH December 14 19 47 at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Dec. 13 1947, and that I last saw h[illegible] alive on Dec. 13 1947.

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Arteriosclerosis

Due to: Myocarditis

Due to: Diabetes Mellitus

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. E. Keedle M.D.

Address 2314-26 W. North Ave Date signed 12/14/47

657941 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. 657941

CERTIFICATE OF DEATH 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 58
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Seven Mile Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James E Lilly

3 (b) If veteran, name war: no | 3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Emily

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1867

8. AGE: Years	Months	Days	If less than one day
90	5	18	hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Farmer (Retired)

11. Industry or business

FATHER
12. Name John Lilly
13. Birthplace Ga

MOTHER
14. Maiden Name Sarah Johnson
15. Birthplace Ga

16 (a) Informant Mrs Mary Ann Hyatt
(b) Address Owings Mills Md

17. Burial (Burial, cremation, or removal) (b) Date thereof 12/16/47 (month) (day) (year)
(c) Cemetery or crematory Sod Shepard
Location Westminster Md

18 (a) Funeral director Wilson & Son
(b) Address 1219 Park Ave

19 (a) DEC 15 1947 (Date rec'd by registrar) (b) Burington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Dec. 1947, at 12:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease with Decompensation

Due to

Other Conditions Fracture, left hip.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 10-17-47 at M.
(b) Where did injury occur? 4 Seven Mile Lane Pikesville, MD
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall from ladder

23. Signature Wm. H. Kammer Jr M.D. Medical Examiner.
Date signed 14 Dec. 47

VS 151

657942 Lefkot

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

657942 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 patapsco St.
(c) Hospital or institution: 235

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 patapsco St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon Lefkot

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-01-5293.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Mary Lefkot

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Feb 27 1885

8. AGE: Years 62 | Months 6 | Days 16. | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Dont. Know

13. Birthplace

MOTHER 14. Maiden Name Dont. Know

15. Birthplace

16 (a) Informant Mary Lefkot.

(b) Address 1727 patapsco St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17 47 (month) (day) (year)

(c) Cemetery or crematory Greden Hill

Location Ritchie Highway

18 (a) Funeral director Martin J Connors

(b) Address 1600 Hollins St.

DEC 15 1947 (Date rec'd by registrar) (b) Funeral from Williams, M.H. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 | 13 | 1947 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 | 10 | 1947 to 12 | 13 | 1947 and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary thrombosis	3 days
Due to	
Due to Hypertension arteriosclerosis	1 year 1 year
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M.D. M. D.

Address 125 N Charles St Date signed

+ 12/15/47.

G57943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓164c

Registered No. G57943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Wilkens Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME CHARLES H. MARFIELD

3 (b) If veteran, name war	3 (c) Social Security Account No. 213-20-4039

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1923

8. AGE: Years	Months	Days	If less than one day
24	10	28	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Punch Press Operator

11. Industry or business Miller Metal Products Co.

FATHER
12. Name Lawrence F. Marfield
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Christina M. Holder
15. Birthplace Balto. Md

16 (a) Informant Lawrence F. Marfield
(b) Address 1810 Wilkens Ave

17 (a) Burial (b) Date thereof 12/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Nuttle
(b) Address 4101 Edmondson Ave

19 (a) DEC 15 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1947, at 2.30 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of heart

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: Found
(a) Date of injury 12-11-47 at 2 P. M.
(b) Where did injury occur? Found- Woods- Western Md. R.R. Gwynns Falls & Edmondson-Balto.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12-12-47

G57944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G57944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pine Ridge Nursing Home
(c) Hospital or institution: 4703 Hamneth Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8322 Old Phila. Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Gettig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pauline B. Gettig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21 - 1872

8. AGE: Years	Months	Days	If less than one day
75	2	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Handyman
11. Industry or business

FATHER
12. Name Conrad Gettig
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Henkel
15. Birthplace Germany

16 (a) Informant Pauline B. Gettig
(b) Address 8322 Old Phila. Rd.

17 (a) Burial (b) Date thereof Dec. 16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Zion Luth. Church Cem.
Location Golden Ring Rd.

18 (a) Funeral director John A. Hyder
(b) Address 2334 Jefferson St.

DEC 15 1947 (b) Kensington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1947 at 6.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 12 1947 and that I last saw h[illegible] alive on Dec 12 1947

Cause	Duration
Immediate cause of death Coronary thrombosis	Sudden
Due to Arteriosclerotic Cardio-vascular disease	1 yr.
Due to	
Other Conditions Osteo-arthritis	2 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Baumgardner M. D.
Address Balto 6 Date signed 12-13-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 657945

657945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 RICHWOOD AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER EMORY STANDIFORD

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-03-8100

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MAUDE GENEVIEVE
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 7/3/78

8. AGE: Years	Months	Days	If less than one day
69	5	10	..... hr. ..... min.

9. Birthplace BALTIMORE MARYLAND
(Town, county, and state)
10. Usual Occupation PRINTER
11. Industry or business
FATHER 12. Name Isaac Collins Standiford
13. Birthplace MD
MOTHER 14. Maiden Name Henrietta Zimmerman
15. Birthplace MD
16 (a) Informant Mrs Maude G. Standiford
(b) Address 605 Richwood Ave
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 16 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Md
18 (a) Funeral director Pottinger Bros
(b) Address 2324 N Charles St
19 DEC 15 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1947, at 4:30 P.M.
I certify that death occurred on the date above stated; that I attended deceased from 12/1 1947, to 12/13 1947, and that I last saw him alive on 12/13 1947.

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE	
Due to	
Other Conditions ASTHMA	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Henry J. Houska M.D.
Address St. Joseph Hosp Date signed 12/13/47

VS 150

G57946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

Registered No. G57946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3163 Lyndale Ave. Lyndale Ave
(If rural, give road number)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME THOMAS PATRICK TROY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4th 1898

8. AGE: Years	Months	Days	If less than one day
50 49	7	8	..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Engineer
11. Industry or business Wirty Electric

FATHER
12. Name Patrick Troy
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Norris
15. Birthplace Ireland

16 (a) Informant Carroll Nagle
(b) Address 3163 Lyndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11th 1947 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Frederick Road

18 (a) Funeral director Leo G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) DEC 15 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1947, at 12.40 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Earle Ryan M.D.
Medical Examiner.

Date signed 12-12-47

X

G57947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57947 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5503 Jonquil Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Corinth
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Bolyard

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Stephen Bolyard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 20, 1868

8. AGE: Years	Months	Days	If less than one day
79	8	23	hr. min.

9. Birthplace: Saltlick, W. Va.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: David A. Nine
13. Birthplace: W. Va.

MOTHER
14. Maiden Name: Sarah E. Shaffer
15. Birthplace: W. Va.

16 (a) Informant: Mrs. Wretha Lodenkemper
(b) Address: 5503 Jonquil Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/16/47 (month) (day) (year)

(c) Cemetery or crematory
Location: Terra Alta, Wa.Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto. 2, Md.

19 (a) DEC 15 1947 (Date received by Registrar) (b) Hunter for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/47 19 , at 7:55 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 12/14/47

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57948

BALTIMORE CITY HEALTH DEPARTMENT ✓ X

CERTIFICATE OF DEATH 127a

Registered No. G57933

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland St
(c) Hospital or institution: Nest Baltimore Gen'l Hosp

(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 1 5
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 Ohio Ave. Balti. Highds.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TERSILIA SERRA

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband of ~~wife~~ Giuseppe Serra
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1868

8. AGE: Years	Months	Days	If less than one day
79	5	24	hr. min.

9. Birthplace S. Giovanni Persiceto Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Gaetano Serra
13. Birthplace Italy

MOTHER
14. Maiden Name Carlotta Serra.
15. Birthplace Italy

16 (a) Informant Emma Nicolai (Daughter)
(b) Address 2927 Ohio Ave Balti. Highnds.

17 (a) Burial (b) Date thereof Dec. 17 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Dalla Rose
(b) Address 52 N. Morley St. Williamsport, Md.

19 (a) DEC 19 1947 (b) Transcribed by [illegible]
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1947, at 1:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1947 to Dec 14 1947, and that I last saw her alive on Dec 14 1947.

Immediate cause of death	Duration
Pulmonary Embolism	
Post operative	
Due to	
Due to	
Other Conditions Acute Cholecystitis Obstruction Common Bile Duct; Fibroma	

(Include pregnancy within 3 months of death)

Date of operation Nov 29 1947

Major findings of operation: Obstruction of Common Bile Duct & Fibroma

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Robert Hasley M. D.
Address Nest Baltimore Gen'l Hosp Date signed 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54B

G57949 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2038 W. North Ave.
(c) Hospital or institution: 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2038 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MILTON FEE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Bertie B. Fee
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 15, 1879
8. AGE: Years 68 | Months 8 | Days 27 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Florence Cremen
(b) Address 2124 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 15 1947 Huntington Williams M.D. (Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1947, at 7:15a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Dec 12 1947 and that I last saw him alive on Dec 12 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: Unknown
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Cushman M.D. M. D.
Address 19 W North Ave Date signed 12/13/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1176

Registered No. 657950

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Lynnbrook Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Frederick Smail, Sr.

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 218-22-7781

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ida May Smail (nee Ambach) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1880

8. AGE: Years	Months	Days	If less than one day
67	8	4	hr. min.

9. Birthplace Providence, R. I. (Town, county, and state)
10. Usual Occupation Comptroller
11. Industry or business

FATHER
12. Name George Smail
13. Birthplace R. I.

MOTHER
14. Maiden Name Susan Sweet
15. Birthplace R. I.

16 (a) Informant Miss Ora M. Smail
(b) Address 2210 Lynnbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 15 1947 (Date received by Registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/47 19 , at 2.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5/47 19 , to 12/13/47 19 , and that I last saw h.l.w. alive on 12/13/47 19

Immediate cause of death	Duration
Uremia	
Due to Subdiaphragmatic abscess	
Due to Localized peritonitis - Fistula - Biliary	
Other Conditions Malignant bleeding peptic duodenal ulcer.	

(Include pregnancy within 3 months of death)

Date of operation 11/14/47

Major findings of operation: Massive bleeding duodenal ulcer Subdiaphragmatic abscess

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Uthria A Bailey M. D.
Address 1400 Caroline Date signed 12/13/47

VS 190

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 1 57951

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 N. East Ave
(c) Hospital or institution: 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 N. East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora McBracken

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Femal | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19 1865

8. AGE: Years: 82 | Months: 2 | Days: 23 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name Louis Kaish
13. Birthplace germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Mr. George McBracken
(b) Address 106 N. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16 1937 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Marie E. Trathowsky
(b) Address 1000 N. Kenwood Ave

19 (a) Dec 15 1937 (b) Huntington Williams, M.D. (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 19 37, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 37 to Dec 12 1937, and that I last saw her alive on Dec 12 1937

Immediate cause of death — Duration

Due to Coronary Thrombosis — 12/12/37

Due to Ch. Myocarditis — 12/8/37

Other Conditions generalized Arteriosclerosis — 1938

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rosario M.D.
Address 801 E Lexington St Date signed 12/14/37

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

Registered No. G57952

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 N. Fremont Ave
(c) Hospital or institution: 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HYMAN BROWN

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bernice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/2/1900

8. AGE: Years 47 | Months 10 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Chestertown, Md.
(Town, county, and state)

10. Usual Occupation Brick Maker

11. Industry or business General Refractories

FATHER
12. Name George Brown
13. Birthplace Chestertown, Md

MOTHER
14. Maiden Name -
15. Birthplace Md

16 (a) Informant Bernice Brown (W)
(b) Address 310 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave
(Date rec'd by registrar) DEC 15 1947 (Huntington Williams, Md)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12th 1947, at 1 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18/47 to 12/12/1947, and that I last saw h- alive on 12/12/47.

Immediate cause of death	Duration
Pulmonary Embolism (Postoperative)	
Due to	
Due to	
Other Conditions Lymphoma Rt upper lung	1 year

(Include pregnancy within 3 months of death)

Date of operation 12/3/47

Major findings of operation: Lymphoma Rt upper lung

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Welcome M. D.
Address 1131 Harlem Date signed 12/16/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 652953

652953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave
(c) Hospital or institution: St. Agnes Hospital 27 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Com Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Mary's Seminary (If rural give location)
Catonsville
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Rosalia Marie (Laskowski)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: — * * *
6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) July 20 1883

8. AGE: Years 64 | Months 63 | Days 4 | 24 | If less than one day * hr. min.

9. Birthplace: Poland (Town, county and state)

10. Usual Occupation Nun (Religious)

11. Industry or business * x

FATHER
12. Name Jacob Laskowski
13. Birthplace Poland

MOTHER
14. Maiden Name Julianna Lyara
15. Birthplace Poland

16 (a) Informant Sister Mary David
(b) Address St. Mary's Seminary. Roland Park

17 (a) Removal (b) Date thereof Dec. 15-4 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory
Location Melbourne, Kentucky

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt Royal Ave

19 DEC 15 1947 (b) Registrar's signature Lexington Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1947 at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1947 to 12-14 1947 and that I last saw h. ex alive on 12-14 1947

Immediate cause of death	Duration
Cerebral Hemorrhage.	
Due to Hypertension	
Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jose L. Valdivieso M. D.
Address St. Agnes' Hospital Date signed 12-14-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57954

A59417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

X ✓ G57954 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County
(c) City or town WARREN. (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Myrtle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSAN Perry

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife: * *
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-46

8. AGE: Years 1 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace California (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER — 12. Name Ned Perry
13. Birthplace Pa.

MOTHER — 14. Maiden Name Charlotte Amodell
15. Birthplace Pa.

16 (a) Informant Records;
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof DEC. 15. 1947 (month) (day) (year)
(c) Cemetery or crematory WARREN, PENNA
Location

18 (a) Funeral director Chas. F. Evans-Son
(b) Address 118 W Mt Royal Ave

19 DEC 15 1947 (Date rec'd by registrar) (b) Washington Willis, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. - 14 - 1947 at 6-00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4- 1947 to 12-14- 1947 and that I last saw h[er] alive on 12-14-1947.

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to HEPATIC INSUFFICIENCY	
Due to CONGENITAL BILIARY ATRESIA - EXTRA + INTRA HEPATIC	
Other Conditions POST-OPERATIVE (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. William A. Spencer M. D.
Address Johns Hopkins Hosp Date signed 12-14-47
Harriet Lane Home

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

057955 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 E. Gittings St
(c) Hospital or institution: 24 - 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 E. Gittings St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph J. Kitchen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary P. Kitchen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26-1863

8. AGE: Years	Months	Days	If less than one day
84	1	19	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business none

FATHER
12. Name Walter Kitchen
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Payson
15. Birthplace Virginia

16 (a) Informant Gibson A. Kitchen
(b) Address 113 E. Gittings St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-1947 (month) (day) (year)
(c) Cemetery or crematory Blanford
Location Petersburg, Virginia

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

DEC 15 1947 (Date Rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1947, at 12:59 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Dec. 13 1947, and that I last saw h[illegible] alive on Dec. 13 1947,

Immediate cause of death	Duration
Chronic myocarditis	
Hemiplegia Aortic Sclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. P. Fruitman M.D.
Address 1319 Light St., Date signed 12/15/47

G57956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓186a

G57956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Agnes Hosp.
(c) Hospital or institution: 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1279 William St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Nora Whettle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Francis M. Whettle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 24-1857

8. AGE: Years 90 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Roan
13. Birthplace Ireland

MOTHER
14. Maiden Name Winfred
15. Birthplace Ireland

16 (a) Informant Dr. Chas. B. Whettle
(b) Address 1279 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) DEC 15 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Dec. 1947 at 12:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease with Auricular Fibrillation

Due to

Other Conditions Fracture, right hip. Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 28 Nov. 1947 M.
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Fell while walking in home

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 14 Dec. 1947

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 657957

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 W. Penna. Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Regina H. Green
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Frederick J. Green
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-18-94
8. AGE: Years 53 Months 11 Days 17 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name James E. Lindsay
13. Birthplace Maryland

MOTHER
14. Maiden Name Kalbfleisch, Regina
15. Birthplace Maryland

16 (a) Informant Frederick J. Green, Jr.
(b) Address Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/47 (month) (day) (year)
(c) Cemetery or crematory Monti Marie
Location Towson Md.

18 (a) Funeral director H. H. Myers and Son
(b) Address 805 N. Calvert St.

DEC 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1947, at 10:10 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1947 to 12-13 1947 and that I last saw her alive on 12-13 1947

	Duration
Immediate cause of death: Pancreatic carcinoma, primary site not known	
Due to	
Due to	
Other Conditions: DCUD	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Carcinomatosis generalized - primary ?
Date of autopsy: Today

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. D.
Address Date signed

Hosp x 12-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G57958 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2.0H.
(c) Hospital or institution: Mercy Hospital 2712
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 Cedarcroft Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C. Flack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife C. Walter Flack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Carl Yeakel
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Weisman
15. Birthplace Maryland

16 (a) Informant Miss Mary Margaret Flack
(b) Address 300 Cedarcroft Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md

18 (a) Funeral director H. H. Myers and Son
(b) Address 805 N. Calvert St.

19 (a) Dec 15 1947 (Date filed by registrar) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1947, at 6 45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubrinski M.D. Medical Examiner.
Date signed 12/17/47

G57959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G57959

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 Frederick Rd #28
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY L. CRAUMER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1867

8. AGE: Years 80 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Maryland (City, county, and state)

10. Usual Occupation Machinist

11. Industry or business Retired

FATHER 12. Name Francis M Craumer

13. Birthplace Pa

MOTHER 14. Maiden Name Louise Minnick

15. Birthplace Md

16 (a) Informant Harry L Craumer

(b) Address 2528 Frederick Rd

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/14/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto City

18 (a) Funeral director Edw S Maitkabb

(b) Address Catonsville Md

19 DEC 15 1947 (b) (Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Dec. 1947, at 6 50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Dec 1947 to 13 Dec 1947, and that I last saw him alive on 13 Dec 1947.

Immediate cause of death	Duration
(1) Cardiac decompensation	
(2) PERITONITIS	1 day
Due to (1) Chr. myocarditis	
(2) Reported urinary bladder	
Due to Carcinoma of bladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Peritonitis, Carcinoma Bladder

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.T. McMorgan M.D.

Address Maryland Gen. Hospital Date signed 13 Dec. 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G57960 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 Rectory Lane
(c) Hospital or institution: 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1015 Rectory Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Malinda Catherine Fisher

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Thomas Fisher
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 9, 1861

8. AGE: Years 86 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Carroll County, Md. (Town, county and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel Dietz
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Lillian Agnes Fisher
(b) Address 1015 Rectory Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director George T. Depkrab
(b) Address 2401 Frederick Ave

19 DEC 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1947, at 7:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1946 to Dec 12 1947, and that I last saw h[illegible] alive on Dec 12 1947

Immediate cause of death: Terminal Hypostatic Pneumonia — Duration: 3 days
Due to: Chronic Cardio-vascular Renal Disease with
Due to: Cardiac decompensation

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 646 W 36 St. Date signed 12/13/47 D

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 557961

557961

MARGIN RESERVED FOR BINDING. The item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2116 E. Fairmount Ave
(c) Hospital or institution: 63

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Basta (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phisip 6. Haas

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha E.
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) June 20 1881

8. AGE: Years 66 | Months 5 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Basta (Town, county, and state)

10. Usual Occupation (Salt)
11. Industry or business Store Keeper

FATHER
12. Name Phisip 6. Haas Sr.
13. Birthplace Basta.

MOTHER
14. Maiden Name ?
15 Birthplace Basta.

16 (a) Informant Bertha E. Haas
(b) Address 2116 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 16 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd.

18 (a) Funeral director Mat. H.E. Dugal
(b) Address 347 S. Ann St.

19 (a) DEC 15 1947 (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1947 at 12:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1947 to Dec 17 1947 and that I last saw h... alive on Dec 17 1947.

Immediate cause of death: Lobar Mycocardial Pneumonia — Duration: 2 days
Due to: Cirrhosis - Sebaceous Hypertension - Cardio - Vascular Disease — 12 yrs.
Due to: Bronchial Asthma.
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Sindler M. D.
Address 1701 E. Fayette St Date signed 12/15/47

X

G57962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 35 N Kenwood Avenue
(c) Hospital or institution: 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 N. Kenwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE ISABELLE HORSTMEIER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Albert W.A. Horstmeier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 21. 1869

8. AGE: Years	Months	Days	If less than one day
78	8	21	hr. min.

9. Birthplace Boston, Mass. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles C. McCloud
13. Birthplace Boston Mass.

MOTHER
14. Maiden Name Elizabeth Leger Davis
15. Birthplace Liverpoole England

16 (a) Informant Mrs. Anton Frederick
(b) Address 35 N. Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (month) (day) (year)
(c) Cemetery or crematory Trinity Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 15 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 12 1947, at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1947 to Dec. 12 1947, that I last saw h. er alive on Dec. 11, 1947.

	Duration
Immediate cause of death: Congeative Heart Failuure	2 days
Due to: Myocardial Damage	Unknown
Arteriosclerosis	Unknown
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philibert Artigenis M.D.
Address 2942 E. Fayette St. Date signed 12/13/47

X

C57963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83a

Registered No. C57963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 E. North Ave
(c) Hospital or institution: 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE FISSEL

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Artis J. Fissel
6 (c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr): June 25, 1863

8. AGE: Years 84 | Months 5 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace: Penna. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Berthold
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth ?
15. Birthplace: Germany

16 (a) Informant: Mr. Artis J. Fissel
(b) Address: 2035 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/47 (month) (day) (year)
(c) Cemetery or crematory: Jefferson Cemetery
Location: York County, Pa.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 DEC 15 1947 Date received by Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 1947 at 3 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1947 to Dec. 13 1947 and that I last saw h[illegible] alive on Dec 9 1947.

	Duration
Immediate cause of death: Apoplectic stroke	
Due to: Arteriosclerosis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Leonard L. Rutter, M.D.
Address 1706 N Wash St Date signed 12/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G57964 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 E. Preston
(c) Hospital or institution: 9.3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 E. Preston (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Eldon Smith (LOUIS ELDON SMITH)

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 213-01-0285

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lillian Marie Akehurst

6 (c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.) Dec. 29 1896

8. AGE: Years 50 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Machinist Foreman

11. Industry or business: Crown Cork & Seal Co.

FATHER
12. Name: Richard I. Smith
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Not Known
15. Birthplace: Maryland

16 (a) Informant: Mrs. Lillian M. Smith
(b) Address: 2435 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 17 1947 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: Baltimore Md.

19 (a) DEC 15 1947 (Date received by registrar) (b) Huntington Williamsville, Md

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/47 19 at 4:55 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Vascular Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Devers M.D.
Medical Examiner.
Date signed 12/14/47

G57965 JL - 36208

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G57965 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jane Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Benjamin (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
86 ?			hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-15-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Hebron
Location Baltimore, Md.

18 (a) Funeral director [illegible] A. Heusler
(b) Address 3745 W. Biddle St.

19 (a) DEC 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1947, at 11.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1938, to Dec. 11 1947 and that I last saw h er alive on Dec. 11 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertension Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D E Robertson Jr M. D.
Address Balt City Hosp Date signed 12/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 657966

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3313 Foster Ave.
(c) Hospital or institution: 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 Foster Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE R. KLEINHENN

3 (b) If veteran, name war: ------

3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	Widowed

6 (b) Name of husband or wife: Charles Kleinhenn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1864

8. AGE: Years	Months	Days	If less than one day
83	5	23	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation House-Work.
11. Industry or business At Home.

FATHER
12. Name Adam Hofmann
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Henry J. Kleinhenn (Son)
(b) Address 620 S. Eaton St.

17 (a) Burial (b) Date thereof 12/16/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd.

18 (a) Funeral director Charles L. Zeiler.
(b) Address 901 S. Conkling St.

DEC 15 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1947, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1947 to Dec 12 1947, and that I last saw her alive on Dec 11 1947

Immediate cause of death	Duration
C. V. Lesion	
Cerebral Hemorrhage	12-7/24
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eadekenmuck M. D.
Address 842 E. 33rd St. Date signed 12-13-47

X

G57967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57967
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 S. Highland Ave.
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 S. Highland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CASPER LONG

3 (b) If veteran, name war	3 (c) Social Security Account No.
-------	-------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth K. Long
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) April 7, 1867.

8. AGE: Years	Months	Days	If less than one day
80	8	7	____hr. ____min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Balto. Copper Mills

FATHER
12. Name John Long
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15 Birthplace Germany

16 (a) Informant Elizabeth K. Long (Wife)
(b) Address 709 S. Highland Ave.

17 (a) Burial (b) Date thereof 12/17/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location 7225 Eastern Ave.

18 (a) Funeral director Charles S. Feiler.
(b) Address 901 S. Conkling St.

19 (a) DEC 15 1947 (b) [illegible] Registrar
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1947, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1947 to Dec 14 1947, and that I last saw him alive on Dec 13 1947.

Immediate cause of death	Duration
C. V. Thrombosis	
Acute Coronary Thrombosis	
Due to Pulmonary Infarction	Dec 1947
Bronchopneumonia	
Due to	
Other Conditions Syph	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address 642 E. 21st Date signed 12-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

G57968 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. 10
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Damon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W

6 (b) Name of husband or wife Agnes Mc Shane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1875

8. AGE: Years	Months	Days	If less than one day
72	1	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Patrick Damon
13. Birthplace

MOTHER
14. Maiden Name Mary Connelly
15. Birthplace

16 (a) Informant Gill Linthicum Hall
(b) Address 1205 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St.

19 (a) (Date received by registrar) (b) Filed at Williamsport, Md.

DEC 19 VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1947, at 4 P. M. sdmd

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Dec 15 1947 and that I last saw him alive on Dec 14 1947.

Immediate cause of death	Duration
Carcinoma Tongue	1 year
Due to	
Due to	
Other Conditions Metastasis in Lungs	6 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall
Address 1631 E North Ave Date signed M. D. 12/15/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

G57969

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 S. Broadway
(c) Hospital or institution: 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1724- E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME OSBORN WATKINS

3 (b) If veteran, name war

3 (c) Social Security Account No. 217011827

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26 1912

8. AGE: Years	Months	Days	If less than one day
34 35	11	18	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Glaser

11. Industry or business

FATHER
12. Name John W. Watkins
13. Birthplace South Carolina

MOTHER
14. Maiden Name Stella R Kirkland
15. Birthplace South Carolina

16 (a) Informant Josephine Watkins
(b) Address 1724 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16/47 (month) (day) (year)
(c) Cemetery or crematory Locust Pt of Mary
Location Baltimore

18 (a) Funeral director Fred W Ogrzewski
(b) Address 1930 Eastern Ave

19 DEC 15 1947 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1947, at 9.15 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at a M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. (Medical Examiner.)
Date signed 12-13-47

VS 151

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G57970 / 48 B

Registered No. G57970

G57970

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3619 Keswick Road
(c) Hospital or institution: 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3619 Keswick Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ruth Luvenia Younger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Samuel George Younger
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 3-1898
8. AGE: Years 49 | Months 11 | Days 10 | If less than one day hr. min.
9. Birthplace Howard Co. Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Charles P. Campbell
13. Birthplace Maryland

MOTHER
14. Maiden Name Bertie M. Smith
15 Birthplace Maryland

16 (a) Informant Samuel G. Younger
(b) Address 3619 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16-1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burger Funeral Home
(b) Address 3631 Falls Road

19 (a) (b) Huntington Williams, Registrar
(Date received by registrar)

DEC 15 1947

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1947, at 1.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Dec 13 1947 and that I last saw h[illegible] alive on 12-13 1947.

Immediate cause of death	Duration
Carcinoma of Lung (secondary to Ca of breast)	3 mo.
Due to	5
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3711 Falls Road Date signed 12-15-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G57971

Registered No. G57971

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2423 Edmondson Ave
(c) Hospital or institution: 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2423 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter R Sydnor

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 - 1858

8. AGE: Years	Months	Days	If less than one day
89	11	4	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Bk W

FATHER
12. Name Walter R Sydnor
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Miss Helen McKenna
(b) Address 2423 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas P Powell
(b) Address 2427 Edmondson Ave

19 (a) [illegible] (b) [illegible] Registered by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1947; at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1947 to 12/13 1947, and that I last saw h[illegible] alive on 12/12 1947.

Immediate cause of death	Duration
Ventricular Fibrillation	12/13/47
Due to Arteriosclerotic Cardiovascular Disease	10+ Yrs
Due to	
Other Conditions D. Patent Ductus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 3629 Edmondson Date signed 12/13/47 M/D

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G57972 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 EMERALD RD. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ARTHUR E. McCAMMON

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife VIOLA E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 9, 1887

8. AGE: Years 60 | Months 1 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation STEAM FITTER

11. Industry or business CURTIS BAY

FATHER 12. Name — McCammon

13. Birthplace Baltimore

MOTHER 14. Maiden Name Kate — — —

15. Birthplace Baltimore

16 (a) Informant Viola McCammon

(b) Address 2908 Emerald Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17/47 (month) (day) (year)

(c) Cemetery or crematory London Pk

Location Baltimore

18 (a) Funeral director Philip Henry Sons

(b) Address 2024 Orleans St

DEC 15 1947 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1947 at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1947 to 12/14 1947 and that I last saw him alive on ____ 19____

Immediate cause of death CARDIAC FAILURE — Duration

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE

Due to ____

Other Conditions LOBAR PNEUMONIA (LEFT LOWER LOBE) (Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature Henry J. Houska M.D. M. D.

Address 4 St. Joseph's Hosp. Date signed 12/14/47

VS 150

Huntington Williams, M.D.

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57923 214357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G57923

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Spring Grove State Hospital
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Matilda Ott

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Div.

6 (b) Name of husband or wife Henry Ott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1884

8. AGE: Years 63 | Months 9 | Days 20 | If less than one day 21 hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Leo. D. Wiber
13. Birthplace ? Germany

MOTHER
14. Maiden Name Louisa D. Schott
15. Birthplace ? Baltimore

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Eutaw St

19 (a) Dec 16 1947 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 19 47 at 2.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1947 to Dec. 13 1947, and that I last saw h. er alive on Dec. 13 1947.

Immediate cause of death Bronchopneumonia

Duration

Due to pulmonary tuberculosis

Due to Carcinoma of thyroid gland

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vinsant M.D.

Address Balto City Hosp. Date signed 13 Dec 47

To be approved. BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 7-7-7
BC x C 98129 CERTIFICATE OF DEATH 159

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B
(c) City or town Baltimore. 25 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Bentalou Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Milewski.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-47

8. AGE: Years	Months	Days	If less than one day
			13 hrs 20 min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name FRANCIS MILEWSKI
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mossie Lewis
15. Birthplace St. Charles Va.

16 (a) Informant FRANCIS MILEWSKI
(b) Address See above.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Anne Arundel County

18 (a) Funeral director Joseph Kaminski Jr
(b) Address 602 Washington Blvd

19 (a) DEC 15 1947 (Date rec'd by registrar) Hattie Williams M.D. Registrar

VS 190 John R. Davis, M.D. per Earl M. Rogers M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1947, at 9:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1947 to 12-13 1947, and that I last saw he alive on 12-13 1947.

Immediate cause of death	Duration
Respiratory failure.	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jose G. Valderas M. D.
Address St Agnes Hosp. Date signed 12-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

657975 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 William St.
(c) Hospital or institution: 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 William St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma M. Haymore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Samuel Haymore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1881

8. AGE: Years 66 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank T. Berg
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Emma Lipps
15. Birthplace Baltimore Md

16 (a) Informant Etta Mae Koch (daughter)
(b) Address 1400 Wilbiam St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec (month) (day) (year)
(c) Cemetery or crematory Dolphin Cemetery
Location Eastern Ave

18 (a) Funeral director Krazer Funeral Home
(b) Address 2116 N Charles St.

19 (a) [redacted] (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1947 at 1.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 19 47 to Dec 12 19 47 and that I last saw h[illegible] alive on 12/12 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to arteriosclerosis	1 yr
Due to Hypertension	17 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Nutter M.D.
Address 1 N Charles S Date signed 12/15/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

The 57978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. 57978

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Forrest St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Maggie Steele

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Alexander

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace..... (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robt. A. Elliott & Dept
(b) Address 1129 N. Caroline St.

19 DEC 15 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1947, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1947 to 12/11 1947 and that I last saw her alive on 12/11 1947

Immediate cause of death: CEREBRAL HEMORRHAGE — Duration: 30 Hours
Due to: Hypertension — 6 years
Due to:
Other Conditions: Lupus Aortitis — 6 years

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Thomas E. Van Metre M.D.
Address Johns Hopkins Hosp. Date signed 12/16/47

VS 150

53a

G57977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G57977 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2203 Wisconsin St
(c) Hospital or institution: 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Wisconsin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob E Miller

3 (b) If veteran, name war: J
3 (c) Social Security Account No. 214-05-3105

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, ~~widowed~~, or divorced

6 (b) Name of husband or wife: Rose E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 3 1886

8. AGE: Years: 61 | Months: 6 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business

FATHER — 12. Name: Edward Miller
13. Birthplace: Balto

MOTHER — 14. Maiden Name: Kate Spellman
15. Birthplace: Maryland

16 (a) Informant: Rose E Miller
(b) Address: 2203 Wisconsin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd

18 (a) Funeral director: Edward Langley
(b) Address: 335-9 Wash Blvd

19 DEC 15 1947 (Date rec'd by Registrar) (b) Transcription for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1947, to Dec. 6 1947, and that I last saw him alive on Dec. 6 1947

	Duration
Immediate cause of death: Coronary Occlusion	12/8/47
Due to:	
Due to: Arterio sclerotic cardio vascular Disease	?
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation: —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury: —

23. Signature: Carl P Rowling M. D.
Address: 1316 W Lombard St Date signed 12/12/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57978 Dr. Kimzey

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G57978

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2701 Polk Street
(c) Hospital or institution: 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 Polk Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Henry Kampes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1877

8. AGE: Years	Months	Days	If less than one day
70	0	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name George Kampes
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Auel
15. Birthplace Germany

16 (a) Informant Mrs. Anna Flayhart
(b) Address 1709 Abbottston Street

17 (a) Burial (b) Date thereof 12-16-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) DEC 15 1947 (Date rec'd by registrar) (b) Huntington Pettibone Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12th 1947; at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 12 1947 and that I last saw h[illegible] alive on Dec 12 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	2 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fritz J Kimzey M. D.
Address 2700 Harford Rd Date signed Dec 14 1947

G57979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 170 B

G57979 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 26-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3619 Brehms Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS F. COLE (3rd)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1928

8. AGE: Years	Months	Days	If less than one day
19	8	10	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Salesman, C. H. Wilson

11. Industry or business Typewriter Supplies

FATHER
12. Name Thomas F. Cole, Jr.
13. Birthplace Md.

MOTHER
14. Maiden Name Eva C. Stock
15. Birthplace Md.

16 (a) Informant Mrs. Eva C. Leonard
(b) Address 3619 Brehms Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) DEC 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1947, at 2.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of Skull
Fracture of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-13-47 at 1 a. M.
(b) Where did injury occur? York & Dunkirk Rd. Balto. Co. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Driver struck street car

23. Signature Earl L. Engle M.D.
Medical Examiner.
Date signed 12-13-47

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G57980

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6-4
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1830 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MAMIE FORD

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
61 8mo			hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Unknown
FATHER 13. Birthplace
MOTHER 14. Maiden Name Sarah Dorsey
MOTHER 15. Birthplace Arkansas

16 (a) Informant Louis Summerville
(b) Address 411 N. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16, 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Hanover Ave Huntington Williams, Md.

19 (a) DEC 15 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1947, at 1.30 P M

21. I certify that I took charge of the remains described above, held an insp & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George B. Merrill M.D. Medical Examiner.
Date signed 12-12-47

VS 181

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G57981

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walker Walter Venable

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-41

8. AGE: Years	Months	Days	If less than one day
6 yrs	3	26	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Venable
13. Birthplace Md

MOTHER
14. Maiden Name Helen Robinson
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec 11 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Baltimore Md

18 (a) Funeral director Elroy O Wilson
(b) Address 1515 Eastern ave

19 (a) DEC 15 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1947 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1947 to Dec 9 1947 and that I last saw him alive on Dec 9 1947

Immediate cause of death	Duration
Anemia mod	One week
Heart failure	
Due to Leukemia	3-4 months
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rudolph Brown M. D.
Address Johns Hopkins Hosp Date signed 12-10-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 657982

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 257 Bethel Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAMIE JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Accomac Co. Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Samuel Watson
13. Birthplace Va

MOTHER
14. Maiden Name Lillie Griffin
15. Birthplace Va.

16 (a) Informant Lillie Watson
(b) Address 207 N. Arsenith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Brooklyn Md

18 (a) Funeral director Elroy Albelson
(b) Address 1500 Brantley Ave

19 (a) DEC 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1947, at M

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lymphatic Leukemia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Beyer M.D. Medical Examiner.
Date signed 12-9-47

VS 181

B.C. = B 96613

G57983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G57983

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: Lockers Hospital 25-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Doctors Hosp. (If rural give location) #101 Audrey Ave
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James W. BRILLON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12/11/47

8. AGE: Years — | Months — | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Lockers Hospital Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James W Brillon
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Johnnie L. Brillon
15 Birthplace Balto, Md. Parsons

16 (a) Informant James W. Brillon
(b) Address 4101 Audrey Ave. Belgium Hyts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location B. & O. Co. Md.

18 (a) Funeral director A. Bayard Freeman
(b) Address 4005 Charles St

19 DEC. 15 1947 (b) Huntington Williams, M.D. (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1947, at 1:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1947, to Dec 13 1947 and that I last saw h[e] alive on Dec 13 1947.

	Duration
Immediate cause of death: Massive Atelectasis (Lungs)	2 hrs.
Due to:	
Due to:	
Other Conditions: Prematurity (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter Kohn M. D.
Address 1026 Fortaw Date signed 12/13/47

161a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered No. G57984

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Latrobe Pk. Lawn.
(c) Hospital or institution: 24-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Latrobe Pk. Lawn. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IRENE M. SEIPP

3 (b) If veteran, name war —
3 (c) Social Security Account No. 2140-0746

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Alfred D. Seipp
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Nov. 3 1907

8. AGE: Years	Months	Days	If less than one day
40	1	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward Bragiis
13. Birthplace Unknown

MOTHER
14. Maiden Name Florence Jeffries
15. Birthplace Baltimore

16 (a) Informant Gilbert Connor
(b) Address 1510 Latrobe Pk. Lawn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location O. C. Co.

18 (a) Funeral director Charles F. Bell
(b) Address 1501 E. Fort Ave

19 (a) [illegible] (b) Huntington Williams, M.D. (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1947, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6 1947, to Dec 12 1947, and that I last saw h[illegible] alive on Dec. 12 1947.

Immediate cause of death	Duration
Due to Hypertension-Cardio-vascular renal disease	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lloyd E. Taylor M.D. M. D.
Address 3902 Greenmount Ave. Date signed 12 Dec 47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

Registered No. G57985

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital 1300
(d) Length of stay in hospital or inst. (~~year, month or days~~) 28
(e) Length of stay in Baltimore (yrs., ~~mos. or days~~) 76

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 742 Reservoir St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph P. Neer

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Helen T. Neer Peters
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Dec 22, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	23	..... hr. ..... min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation Cotton Textiles
11. Industry or business Manufacturer's Agents

FATHER
12. Name N. Frank Neer
13. Birthplace Virginia

MOTHER
14. Maiden Name Catherine Malloy
15. Birthplace New York State

16 (a) Informant Self
(b) Address 742 Reservoir St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

Dec 19 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Dec 1947, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Nov 1947, to 14 Dec 1947, and that I last saw h/M. alive on 14 Dec 1947

Immediate cause of death	Duration
Myocardial degeneration	1 wk
Due to Arterio-sclerosis	Unknown
Due to	
Other Conditions Aneurysm of abdominal aorta	4 yrs ?

(Include pregnancy within 3 months of death)
Date of operation 3 Dec 47
Major findings of operation: Aneurysm abd. aorta
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard M. Barnett
Address Church Home + Hosp Date signed 17 Dec 47

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G57986

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3803 Egerton Road
(c) Hospital or institution: 1510
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3803 Egerton Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA FULD STERN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Sigmund Stern.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 30, 1866.

8. AGE: Years	Months	Days	If less than one day
81	8	15	hr. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Meyer Fuld,
13. Birthplace Germany.

MOTHER
14. Maiden Name Babette Strauss,
15. Birthplace Germany.

16 (a) Informant Mrs. Justin M. Rosenthal,
(b) Address 3803 Egerton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12. 17. 47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levin Funeral Home
(b) Address 1902 Eutaw Place.

19 (a) [illegible] (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15th. 1947 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1931 to Dec 15 1947.
and that I last saw h[illegible] alive on Dec 14 1947.

Immediate cause of death: General arterio sclerosis — Duration 5 yrs
Chronic Myocarditis — 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melvin L. Solomon M. D.
Address 129 S. Broadway. Date signed 12/15/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G57987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G57987

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 160 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary L. Addison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1890

8. AGE: Years 79 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Woodstock, Md. (Town, county, and state)

10. Usual Occupation Milliner

11. Industry or business

FATHER
12. Name Alfred Marshall
13. Birthplace Charles Co. Md.

MOTHER
14. Maiden Name Elizabeth Chapman
15. Birthplace Charles Co. Md.

16 (a) Informant Mrs. Delores Locklear
(b) Address 160 Division St.

17 (a) Burial (burial, cremation, or removal) (b) Date thereof Dec. 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Jas. Wm. H. Holland
(b) Address 1691 Druid Hill Ave.

19 (a) DEC 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1947 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1947 to Dec 15 1947, and that I last saw h[illegible] alive on Dec 14 1947.

Immediate cause of death: Cerebral hemorrhage — Duration: 5 days

Due to: Essential hypertension — Duration: ?

Due to:

Other Conditions: Paralysis of left side (Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature George McDonald M. D.
Address 844 N Carey Date signed 12/15/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657988 URIK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

657988 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Fayette & Calhoun Sts.
(b) Street address 3709 Decanter Rd.
(c) Hospital or institution: Franklin Square Hospt 9-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 Gleaden Ave
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Urik, James Conrad

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of ~~husband or wife~~ Father-Steve

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28-1947

8. AGE: Years | Months: 3 mos. | Days: 14 | If less than one day: hr. min.

9. Birthplace Balto. (3.5.M.) (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER: 12. Name Steve Urik
13. Birthplace Penn.

MOTHER: 14. Maiden Name Berg, Dorothy
15. Birthplace Penn

16 (a) Informant Steve Urik (Father)
(b) Address Same.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16 1947 (month) (day) (year)

(c) Cemetery or crematory
Location Youngsville Pa

18 (a) Funeral director John A Doran
(b) Address 900 E Baltimore St

19 DEC 15 1947 Huntington Williams, M.D. 12/13/47

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 1947 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1947 to 12/12 1947, and that I last saw ~~deceased~~ alive on Nov 25 1947

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Bronchopneumonia Atelectasis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard J. Apperson, M.D.
M. D.
Address 1 Eden St. Date signed 12/13/47

Howard J. Apperson, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57989 HACKMANN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318 Registered No. G57989

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 S. Galveston Road
(c) Hospital or institution: " 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) "
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 129 S. Galveston Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert H. Hackmann

3 (b) If veteran, name war " | 3 (c) Social Security Account No. "

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife "

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3, 1891

8. AGE: Years 56 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Tobacco Dyer

11. Industry or business Self

FATHER 12. Name Henry H. Hackmann

FATHER 13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Germany

16 (a) Informant Mrs Florence Hackmann

(b) Address 129 S. Galveston Road

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)

(c) Cemetery or crematory Dove Cathedral

Location 4300 Old Frederick Road

18 (a) Funeral director John J. Conway & Son

(b) Address 941-43 Hollins St.

19 (a) Date received [illegible] Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1947, at 3:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12/1947 to 12/15/1947 and that I last saw h[illegible] alive on 12/14/1947.

Immediate cause of death

(a) Uremia

Due to (b) Chr. Nephritis

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation "

Major findings of operations "

of autopsy "

Duration: (a) 4 days (b) (c)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 1933 W. Balto St Date signed 12/15/47 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

057990 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 N. Durham Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW G. DOBIHAL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1891

8. AGE: Years	Months	Days	If less than one day
56	10	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Milkman
11. Industry or business

FATHER
12. Name Anton Dobihal
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Barbara Holub
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Agnes Horky - sister
(b) Address 803 N. Port Street

17 (a) Burial (b) Date thereof 12/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (Date received by Registrar) DEC 15 1947 Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1947, at 11.05 P.M.

21. I certify that I took charge of the remains described above, held an inqu. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Rizer M.D.
Medical Examiner
Date signed 12-13-47

G57991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G57991 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1718 Holbrook St.
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 Holbrook St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW H. METTEE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Annie L. Mettee (nee Young) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1865

8. AGE: Years	Months	Days	If less than one day
82	1	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Mettee
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Sommerson
15. Birthplace Pa.

16 (a) Informant Miss Myrtle M. Mettee
(b) Address 1718 Holbrook St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 15 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1947, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1947 to Dec 14 1947 and that I last saw h[illegible] alive on Nov 17 1947.

Immediate cause of death	Duration
Acute cardiac decompensation	
Due to arteriosclerotic Cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jack J. Singer
Address 504 E. North Ave. Date signed 12-[illegible]-47

VS 150

Dr Treland 1579992

1219 Poplar Grove St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 1579992

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2729 Winchester St
(c) Hospital or institution: 167
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2729 Winchester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Agnes Curley

3 (b) If veteran, name war

3 (c) Social Security Account No. Single

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19 1874

8. AGE: Years	Months	Days	If less than one day
73	9	24	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name William Curley
13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Leach
15. Birthplace Ireland

16 (a) Informant Helen V. Curley
(b) Address 2729 Winchester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16-47 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Balto. Md.

18 (a) Funeral director Thomas J. Kenny Inc.
Address 1715 Mallins + Gilmor Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1947 at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1947 to Dec 13 1947 and that I last saw h alive on Dec 12 1947

Immediate cause of death Coronary Thrombosis

Due to Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration
✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work?
(e) Means of injury ✓

23. Signature Helen V. Curley
Address 1219 Poplar Grove St (Date signed) 12/14/47

G57993 ✓ X G57993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution:
Dan Lucas Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Port Deposit
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Billy Ray Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/23/42

8. AGE: Years	Months	Days	If less than one day
	1	23	hr. min.

9. Birthplace Havre de Grace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name H. Ray Anderson
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Hospital Records.
(b) Address 2025 W. Fayette St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17, 1942 (month) (day) (year)

(c) Cemetery or crematory Oak Grove
Location Churchville, Harford Co. Md

18 (a) Funeral director Lee A. Jatterson & Son
(b) Address Perryville, Md

19 (a) DEC 16 1942 (Date rec'd by registrar) (b) Huntingtr Williams M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1942 at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1942 to Dec 15 1942 and that I last saw h/M alive on Dec. 15 1942

Immediate cause of death Malnutrition, dehydration, respiratory failure.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Sub-arachnoid hemorrhage

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul D. Manning M. D.
Address Dan Lucas Hosp. Date signed 12/17/42

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G57994

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Sylvan Av. (28)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Granville H. Triplett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Gertrude L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name John Edwin
13. Birthplace Va.

MOTHER
14. Maiden Name Carrie Johnston
15. Birthplace Va

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 17 47 (month) (day) (year)
(c) Cemetery or crematory
Location Shepherdstown, W. Va

18 (a) Funeral director Dyer B. Fenley
(b) Address Fayette St + Fulton Av.

19 DEC 16 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 190 Jo by machine

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14 1947, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1947, to 12-14 1947, and that I last saw him alive on 12-14 1947.

	Duration
Immediate cause of death Cardiac failure	
Due to myocardial infarction	
Due to coronary occlusion	
Other Conditions arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. B. Kearne M. D.
Address Univ. Hosp. Date signed 12-17

65795 X 65795

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 26a

Registered No. 65795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Queen Anne
(c) City or town Stephensville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Robinson ✓

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Married

6 (b) Name of husband or wife Charles Robinson
6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) Mar 25 1898

8. AGE: Years	Months	Days	If less than one day
49	8	19	hr. ___ min.

9. Birthplace Stephensville Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Wright
13. Birthplace Stephensville

MOTHER
14. Maiden Name Julia Robinson
15. Birthplace Stephensville

16 (a) Informant Mrs Marion
(b) Address Stevensville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-47 (month) (day) (year)
(c) Cemetery or crematory Church Cemetery
Location Stevensville Md
18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W Montgomery St

19 DEC 16 1947 (Signature of local registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1947, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1947 to 12/13 1947, and that I last saw her alive on 12/13 1947.

Immediate cause of death Heart failure
a Pulmonary Edema — Duration 3 hrs

Due to Tuberculosis — Duration years

Due to

Other Conditions Hypertension Cardiovascular Disease
(Includes pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry V. Chase M.D.
Address Mercy Hospital Date signed 12/15/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G57996

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22-
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Gertrude FITZGERALD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace (Town, county, and state) —

10. Usual Occupation None

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Bertha Brown

(b) Address 817 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location Balto City

18 (a) Funeral director Harold L Brown & Son

(b) Address 1000 W Montgomery St

19 (a) DEC 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1947, at 12.10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L Merrill M.D. Medical Examiner.

Date signed 12/12/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947a

Registered No. 6579-47

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 Ashburton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 Ashburton
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Streebig

3 (b) If veteran, name war: NONE

3 (c) Social Security account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie M-

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 1880

8. AGE: Years 67 | Months 6 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER
12. Name William Streebig
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Rausch
15. Birthplace Md.

16 (a) Informant Mrs Bessie Streebig
(b) Address 1731 Ashburton St

17 (a) Dec 17-47 (Burial, cremation, removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Carrolls Chapel
Location Balto. Co- Md.

18 (a) Funeral director Wilson Cook Inc
(b) Address 1717 St. Paul St.

19 (a) DEC 16 1947 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1947 at 3.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1947 to Dec 14 1947 and that I last saw him alive on Dec 13 1947

Immediate cause of death: Coronary — Duration: ✓

Due to: Cardiosclerosis — Duration: 2 years

Due to: Bronchial Asthma

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: ✓

of autopsy: autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work? ✓
(e) Means of injury ✓

23. Signature Edna L. Jackson M.D.

Address 1719 Eutaw St. Baltimore Md. Date signed 12/16/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

657998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

657998 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Buena Vista Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Michel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Lida Michel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/19/1701

8. AGE: Years	Months	Days	If less than one day
45	11	25	hr. min.

9. Birthplace N.J. (Town, county, and state)
10. Usual Occupation Hotel Operator
11. Industry or business Hotel

FATHER
12. Name August Michel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Germany

16 (a) Informant Lida M. Michel
(b) Address 4101 Buena Vista Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 DEC 16 1947 (Date rec'd by Registrar) (Huntington Williams, M.D.) Registrar

VS file 1A1A

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1947 at 6:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7-8 1947 to Dec. 14 1947 and that I last saw him alive on Dec. 14 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Myocardial infarction	
Due to Concurrent coronary occlusion	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul O. Peters M. D.
Address Bon Secours Hosp. Date signed 12/16/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. G57999

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 W. Lafayette ave
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 W. Lafayette Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Virgil M. Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Margaret Reynolds
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19 1868

8. AGE: Years	Months	Days	If less than one day
79	9	24	hr. min.

9. Birthplace Lancaster Pa.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Building

FATHER
12. Name Harrison Reynolds
13. Birthplace Penna.

MOTHER
14. Maiden Name Anna (Unknown)
15. Birthplace Penna.

16 (a) Informant Marshall G. Reynolds
(b) Address 1925 W. Lafayette Ave.

17 (a) Burial (b) Date thereof 12/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baptist Church
Location Hereford Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul st.

19 DEC 16 1947 (b) Huntington Williams Mgr
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13th 1947, at 12 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 12/13/47 19, and that I last saw h~~e~~r alive on 12/10/47 19.

Immediate cause of death	Duration
Anaemia	2 days
Due to Nephritis	unknown
Due to Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter J. Bowen M. D.
Address 404 Edmondson Date signed 12/14/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 058000

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave.
(c) Hospital or institution:
Maryland General Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3132 Remington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles M. Tarbert

3 (b) If veteran, name war	3 (c) Social Security Account No. 717-07-7958

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of ~~husband or~~ wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 26th 1882

8. AGE: Years	Months	Days	If less than one day
65	0	19	hr. min.

9. Birthplace Harford Co. Md
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Penna. R.R.

FATHER
12. Name John A. Tarbert
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Georgia Liffle
15. Birthplace Balto. Co. Md.

16 (a) Informant Rebecca L. Tarbert
(b) Address 3132 Remington Ave

17 (a) Burial (b) Date thereof 12/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1200 Edmondson Ave

19 DEC 16 1947 (c) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Dec 1947, at 12:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Dec 1947, to 15 Dec 1947, and that I last saw him alive on 15 Dec 1947.

Immediate cause of death	Duration
Renal Failure	3 days
Due to Hypertensive Cardio-vascular disease	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Allan Lyon M. D.
Address Md. Gen. Hosp. Date signed

Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65-8001

65-8001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1827 N. Calvert St.
(c) Hospital or institution: 12-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ANN FLEAGLE

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: Robert Noah Fleagle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 27, 1864

8. AGE: Years	Months	Days	If less than one day
83	5	16	hr. min.

9. Birthplace: Hanover, Pa.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: Absalom Moul
13. Birthplace: Hanover, Pa.

MOTHER
14. Maiden Name: Anna Mary Bechtel
15. Birthplace: Hanover, Pa.

16 (a) Informant: Mr. Robert Fleagle, Sr.
(b) Address: 1827 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/47 (month) (day) (year)
(c) Cemetery or crematory: Pleasant Valley Cem.
Location: Carroll Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 DEC 16 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 19 47 at 9:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 37 to Dec. 13 1947, and that I last saw her alive on Dec. 12 1947

Immediate cause of death: Final stage of General Arteriosclerosis — Duration: 10 yrs.
Due to: { Arteriosclerotic Heart Disease / Cerebral Arteriosclerosis — 5 yrs.
Due to
Other Conditions: Malnutrition
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Robert W. Garis
Address: 1103 St. Paul St. Date signed: M./D. 12/15/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 658002

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6015 Pimlico Rd.
(c) Hospital or institution: 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6015 Pimlico Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNIE A. WAHL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Michael J. Wahl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1868

8. AGE: Years	Months	Days	If less than one day
79	4	2	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name - Stokes
13. Birthplace England

MOTHER
14. Maiden Name -
15. Birthplace England

16 (a) Informant Mrs. Samuel F. Roche
(b) Address 6015 Pimlico Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 DEC 16 1947 (Date rec'd by registrar) (by) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1947 to Dec 13 1947 and that I last saw h alive on Dec 13 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Arteriosclerosis	7 7 7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel F. Roche M. D.
Address 5611 Pimlico Rd Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G58003 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 S. Paca St.
(c) Hospital or institution: 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 S. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOIS E. CRUMP

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Geo. W. Crump
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1869

8. AGE: Years	Months	Days	If less than one day
78	1	6	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name - Stark
13. Birthplace Penna.

MOTHER
14. Maiden Name Naomi Hoover
15. Birthplace Penna.

16 (a) Informant Mrs. C. L. Schindhelm
(b) Address 617 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem. Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 16 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1947 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1942 to 12/12 1947, and that I last saw her alive on 12/12 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	1 day
Due to Hypertensive Arterio Sclerotic Cardiovascular Disease	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Carl Carty M. D.
Address 6794 Arlington Ave. signed 12/15/47

X

G58004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G58004

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME C. WILBUR MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 12 1911

8. AGE: Years	Months	Days	If less than one day
36 35	9	3 2	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name C Wilbur Miller
13. Birthplace Md

MOTHER
14. Maiden Name Edith Danson
15. Birthplace Md

16 (a) Informant Hosp. Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16 1947 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Northington Valley Md

18 (a) Funeral director Henry W. Jenkins Sons
(b) Address McCulloh & Richard Sts

19 (d) DEC 16 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1947, at 9.45 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 4/1

(a) Date of injury 12-13-47 at 3 P. M.
(b) Where did injury occur? 300 block N. Charles St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian-struck by bus

23. Signature: Earl L [illegible] M.D.
Medical Examiner.
Date signed 12-15-47

G58005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125 B

G58005

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 1228 E Madison St
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 10-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 E Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES ISAIAH WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1908

8. AGE: Years	Months	Days	If less than one day
39	3	1	hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charlie Williams
13. Birthplace S. C.

MOTHER
14. Maiden Name Jeanie Rochelle
15. Birthplace S. C.

16 (a) Informant Mary Williams
(b) Address 1228 E. Madison St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 18/47 (month) (day) (year)
(c) Cemetery or crematory
Location Blackstock, S. C.

18 (a) Funeral director Mrs. Lobt. A. Elliott Dept.
(b) Address 1129 N. Carrollton St.

DEC 16 1947 (Date rec'd by registrar) (b) Huntington-Williams Mfg. Co.

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17, 1947 at 9:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of Heart
Edema of lungs
Passive congestion of liver, spleen, and kidneys

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 12/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

658006 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3802 Primrose Ave
(c) Hospital or institution: -
27-19
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3802 Primrose Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) **FULL NAME** Edward Ferdinand Constantine

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Susan G. Constantine (nee Unler)
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 1 1854

8. AGE: Years 93 | Months 8 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore County Md (Town, county, and state)
10. Usual Occupation Retired stone mason
11. Industry or business " contractor

FATHER
12. Name William Alfred Constantine
13. Birthplace Unknown

MOTHER
14. Maiden Name Zenobia Parrish
15. Birthplace Unknown

16 (a) Informant Mrs John Brennan
(b) Address 3802 Primrose Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17 1947 (month) (day) (year)
(c) Cemetery or crematory Reisterstown Meth Cemetery
Location Reisterstown Md

18 (a) Funeral director Wm Berryman & Sons
(b) Address Reisterstown Md

DEC 16 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1947 at 730 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to Dec 7th 1947 and that I last saw h[illegible] alive on Dec 7th 1947

Immediate cause of death ____ Duration
Pneumonia ____
Due to Carcinoma of Pancreas 2 months
Due to ____
Other Conditions ____
(Include pregnancy within 3 months of death)
Date of operation ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____
23. Signature A. L. Lemmel M. D.
Address 4379 Liberty Heights Ave Date signed Dec 15

C58007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C58007 131a

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1528 Brunt Street
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 Brunt St. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Frances McCleaver or McKeen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daniel McCleaver

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 1/11/'03

8. AGE: Years 44 | Months 11 | Days 3 | If less than one day: hr. min.

9. Birthplace Chesterfield, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Emmitt Woolridge
13. Birthplace Chesterfield, Va.

MOTHER
14. Maiden Name Olivia Kregg
15. Birthplace Chesterfield, Va.

16 (a) Informant Walter Woolridge
(b) Address 1529 Brunt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/ 17/'47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh St.

19 DEC 16 1947 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1947 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1947 to 12/14 1947 and that I last saw h[illegible] alive on 12/14 1947.

Immediate cause of death: Cardiac Renal — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Hatcher M.D.
Address 1 x 85 Date signed 12/15/47

BCH J-88899

G58008

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 106a

Registered No. G58008

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 578 Baker St.
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 578 Baker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EARL DAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/7/47

8. AGE: Years	Months	Days	If less than one day
	3	4	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation 7

11. Industry or business

FATHER 12. Name James Mullin

13. Birthplace Md

MOTHER 14. Maiden Name Cordynor Day

15. Birthplace Md

16 (a) Informant James Mullin

(b) Address 5-26 Linden Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof Dec 16 1947 (month) (day) (year)

(c) Cemetery or crematory MX Calvary

Location

18 (a) Funeral director Adolphus Hostler

(b) Address 2 E Dent St Balto

19 DEC 16 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1947 at 10.20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute tracheobronchitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-12-47

C58009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. C58009

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3331 Dolfield Ave
(c) Hospital or institution: 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3331 Dolfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna M Blum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17, 1907

8. AGE: Years	Months	Days	If less than one day
40	9	28	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Samuel Merican
13. Birthplace New York City

MOTHER
14. Maiden Name Yetta Yaffe
15. Birthplace Riga

16 (a) Informant Samuel Merican
(b) Address 3331 Dolfield Ave

17 (a) Burial (b) Date thereof Dec 17, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) DEC 16 1947 (b) Huntington Woods, Md.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION 7.15

20. DATE OF DEATH December 15 1947, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1947 to Dec 15 1947 and that I last saw h[illegible] alive on 12/14 1947.

	Duration
Immediate cause of death Pulmonary oedema	1 day
Due to Chronic nephritis - Hypertension	?
Due to Kidneys removed 3 years ago and recurrent kidney sclerotic	
Other Conditions and atherosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Levinson M. D.
Address 1124 W Lafayette Ave Date signed 12/15/47

X

65010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 65010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 S Rappala
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 S Rappala
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George M Baier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1869

8. AGE: Years 78 | Months 9 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation (Retired Baltimore Grand?

11. Industry or business

FATHER
12. Name John M Baier
13. Birthplace Md

MOTHER
14. Maiden Name Mary Dedesman
15. Birthplace Md

16 (a) Informant Mrs Strunkan
(b) Address 37 Lilly Parkway

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 17 '47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 DEC 16 1947 (Date rec'd by registrar) (b) Burial permit issued by Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1947, at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1947 to Dec 14 1947 and that I last saw h. alive on Dec 13 1947

Immediate cause of death	Duration
Chr. Myocarditis	
Due to Chr. Bronchitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Lawlor M.D.
Address 441 E Eager St Date signed 12/16/47

X

G58011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G58011 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 S. Decker Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fanny Roxanna Wells

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married Widowed

6 (b) Name of husband or wife John B. Wells

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/23/1869

8. AGE: Years 78 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore County Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Jordan
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Sellers
15. Birthplace Balto

16 (a) Informant John Kramer
(b) Address 610 S Decker

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16-47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Eleanor

19 DEC 16 1947 (Date rec'd by registrar) (Signature) Washington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 1947 at 8:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7 1947 to 12/12 1947, and that I last saw h ER alive on 12/12 1947

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Generalized Carcinomatosis	
Due to Carcinoma of Bladder	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry T. Wilson, Jr. M.D.
Address St. Joseph's Hosp Date signed 12/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G58012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2729- Jefferson St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME LEONARD SULLIVAN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha Sullivan
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 17 - 1884

8. AGE: Years	Months	Days	If less than one day
63	6	28	....hr. ....min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Bank Runner

11. Industry or business

FATHER
12. Name Wesley Sullivan
13. Birthplace Balto

MOTHER
14. Maiden Name Dont Know
15. Birthplace Dont Know

16 (a) Informant Mrs Dorothy A Sultz
(b) Address 1401 E Clement St

17 (a) Burial (b) Date thereof Dec 17th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Catonsville

18 (a) Funeral director Ellis & Funeral Home
(b) Address 2008 Orleans St

19 (a) DEC 16 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1947, at 2.15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to.....

Other Conditions Fract. Rt. elbow, left wrist, Fract. of skull.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Carl A Royer M.D.
Medical Examiner

Date signed 12-15-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G58013
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore - 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Patapsco St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr ROBERT HENRY FRITSCHE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Amelia Fritsche
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1879

8. AGE: Years 68 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Germany
(Town, county and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Henry Fritsche
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Gnor
15. Birthplace

16 (a) Informant Wife
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location City

18 (a) Funeral director Elliott Funeral Home
(b) Address 200 E Orleans St

19 (a) DEC 16 1947 (b) Huntington Williams M.D.
(Date the Physician last saw deceased) (Physician's name)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14-1947 at 7.55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3-1947 to 12-14 1947 and that I last saw him alive on 12-14-1947

Immediate cause of death Bronchopneumonia, Coronary Occlusion — Duration 36 hrs

Due to — Duration —

Due to — Duration —

Other Conditions Emphysema, Malnutrition — Duration unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert M. Carouge M. D.
Address 6226 Everall Ave. Date signed 12-14-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58014

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1926 Orleans St
(c) Hospital or institution: 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Orleans
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife James Johnson
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug 19 1892

8. AGE: Years	Months	Days	If less than one day
55	3	26	hr. min.

9. Birthplace Balto (Town, county and state)
10. Usual Occupation Sales Lady
11. Industry or business Arundel Ice Cream

FATHER
12. Name James F. Douglas
13. Birthplace Balto

MOTHER
14. Maiden Name Elizabeth F Bauer
15. Birthplace Balto

16 (a) Informant James Johnson
(b) Address 1926 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18 47 (month) (day) (year)
(c) Cemetery or crematory Bonnet Bell Cem
Location Cty

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans

19 (a) DEC 16 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1947, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1947 to Dec 14 1947 and that I last saw her alive on Dec 13 1947.

Immediate cause of death	Duration
Coronary Thrombosis	2 wks
Due to Arteriosclerosis	
Hypertensive Cardio-vascular Rs	10 Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Gunter M. D.
Address 170 E Fayette St Date signed 12-14-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

658015 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 E Chase St
(c) Hospital or institution: 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 E. Chase st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wilhelmina Hoffmann

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Wm Hoffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2- 1860

8. AGE: Years 87 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Henury Path

13. Birthplace Germany

MOTHER 14. Maiden Name Dont Knows

15. Birthplace Ger

16 (a) Informant Mary R Linder

(b) Address 286 f Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17/47 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto

18 (a) Funeral director Welsh Funeral Home

(b) Address 2008 Orleans

19 DEC 16 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14th 1947, at 5 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23- 1945 to 12-13- 1947 and that I last saw her alive on 12-13- 1947

Immediate cause of death Carcinoma of Liver — Duration 1 yr.

Due to

Due to

Other Conditions Cardio-vascular renal Disease — 2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melton C. Chaney M. D.

Address 2117 Belair Rd Date signed 12-16-47

X

638013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 638013

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2115 EDMONDSON AVE
(c) Hospital or institution: 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 EDMONDSON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID ANBINDER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ROSE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/ 1891

8. AGE: Years	Months	Days	If less than one day
56 (55)	8		hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation CONFECTIONERY STORE
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15 Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-16-47 (month) (day) (year)
(c) Cemetery or crematory MISHKON ISRAEL
Location SOUTHERN AVE

18 (a) Funeral director VOCK LEWIS INC
(b) Address 2400 EUTAW PL.

19 (a) DEC 16 1947 (Date received by registrar) (b) [signature] Registrar

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1947 at 2.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Dec 16 1947, and that I last saw him alive on Dec 16 1947.

Immediate cause of death Acute Pulmonary Oedema.
Due to Hypertensive Cardio-Vascular Disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Seacrist M. D.
Address 1x 2400 Eutaw Pl. Date signed 12/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No. 58017

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2120 N. Howard St.
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PATSY BURRELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1873

8. AGE: Years	Months	Days	If less than one day
74	-	7	hr. min.

9. Birthplace Gloucester Co., Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James H. Brooks
13. Birthplace Va.

MOTHER
14. Maiden Name Louise Tazwell
15. Birthplace Va.

16 (a) Informant Mrs. Lena Smith
(b) Address 2120 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-47 (month) (day) (year)

(c) Cemetery or crematory
Location Gloucester Co., Va.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) DEC 16 1947 (Date rec'd by registrar) (b) Hunting[illegible]

V S 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH December 13 1947, at 12:45

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Dec 13 1947 and that I last saw h[illegible] alive on Dec 13, 1947.

Immediate cause of death: Cardiac Renal Disease — Duration

Due to — 24 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 2829 Jeanes St Date signed Dec 16 1947

X

658018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 658018

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Rayner Ave.
(c) Hospital or institution: WBGH.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town White Hall, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna L. Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife William C. Norris

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1880

8. AGE: Years 67 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Phoenix, Maryland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Thomas C. Kemp

13. Birthplace Unknown

MOTHER 14. Maiden Name Belinda Patterson

15. Birthplace Phoenix, Maryland

16 (a) Informant W. C. Norris

(b) Address White Hall Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17-1947 (month) (day) (year)

(c) Cemetery or crematory Worthington Chapel

Location White Hall R.F.D. #1

18 (a) Funeral director Howard S. Mankins

(b) Address White Hall, Md

19 DEC 16 1947 (Date rec'd by registrar) Awaiting for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 | 14 | 1947 at 12'8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 | 13 | 1947 to 12 | 14 | 1947 and that I last saw her alive on 12 | 14 | 1947

Immediate cause of death: Cardiac failure — Duration

Due to: Hypertensive C.V.D.

Due to:

Other Conditions: Auricular Fibrillation

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C. Hatcher M.D.

Address WBGH. Date signed 12/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49c

Registered No. 58019

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 20-5
(b) Street address Caton + Wilkens ave.
(c) Hospital or institution:
St. agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2535 Frederick ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda A. Della Hobbs.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-24-8903

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1882

8. AGE: Years	Months	Days	If less than one day
66 65	5	18	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Albert R. Ramsey
13. Birthplace Md.

MOTHER
14. Maiden Name Mary J. Neiden.
15. Birthplace Md.

16 (a) Informant Mrs. Edith Rabe.
(b) Address 315 S. Franklin Town Rd

17 (a) Burial (b) Date thereof 12/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westens
Location Balto Md

18 (a) Funeral director Geo L Beyer Jr
(b) Address 1512 Hollins St

19 DEC 16 1947 (Signature) Huntington Williams, M.D.
(Date received by Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1947, at 3 05 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1947 to 12/12 1947 and that I last saw h.e. alive on 12/12 1947.

Immediate cause of death: Uremia

Due to Carcinoma of the stomach

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert J. Lineaker M.D.
Address St. Agnes Hospital Date signed 12/12/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

058020 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2573 Frederick, Ave.
(c) Hospital or institution: 205
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2573 Frederick, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence E. Orem.

3 (b) If veteran, name war: none.

3 (c) Social Security Account No. 220-24-7371

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Charles E. Orem.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June-15-1883

8. AGE: Years 64 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Carroll Co. - Md. (Town, county, and state)

10. Usual Occupation House Wife.

11. Industry or business

FATHER
12. Name Tom Marsh.
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Jones.
15. Birthplace Md.

16 (a) Informant Mrs. Charles E. Orem.
(b) Address 456-S. Furrow St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Dec. 17/47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick, Ave.

19 DEC 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December, 14 - 1947, at 630 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947, to Dec 14 1947, and that I last saw her alive on Dec 14 1947.

	Duration
Immediate cause of death: Acute Cardiac Dilatation	1 day
Due to: Hypertensive Cardio-Vascular disease	2 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 1607 Mass. Ave. Date signed Dec 16/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G58021 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18-3
(c) Hospital or institution: Mercy Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 S Carlton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUDREY DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1931

8. AGE: Years 16 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore md.
(Town, county, and state)

10. Usual Occupation School child

11. Industry or business

FATHER
12. Name William Davis
13. Birthplace Va.

MOTHER
14. Maiden Name Gertrude Johnson
15. Birthplace Maryland

16 (a) Informant Gertrude J. Davis
(b) Address 30 - S. Carlton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927-N. Mount St.

DEC 16 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/47 19 , at 3:50 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 12/14/47

X

658022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

295-613 / 137a

Registered No. 658022

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 W. LOMBARD, ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph DYSON (young)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-29-87

8. AGE: Years	Months	Days	If less than one day
60	3	16	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Dallas Dyson
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline ?
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balto. Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressman

19 (a) DEC 16 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-14- 1947 at 4 15- A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19- 1947, to 12-14- 1947, and that I last saw h[illegible] alive on 12-14- 1947.

Immediate cause of death	Duration
Uremia	
Due to Hydronephrosis	
Due to Benign Prostatic hypertrophy	
Other Conditions Uremic Colitis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman M. Mellinkoff M.D.
Address Johns Hopkins Hosp. Date signed 12/17/47

G58023 ABIGAIL

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G58023

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore G. H. 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 843 N 34th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abigail Warner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George Warner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31-1881

8. AGE: Years 66 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER 12. Name Nicholas Wolfe
13. Birthplace Md

MOTHER 14. Maiden Name Virginia Kullem
15. Birthplace —

16 (a) Informant George H. Warner
(b) Address 843 N 34th St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12-17-47 (month) (day) (year)
(c) Cemetery or crematory London Pk
Location Baltimore Md

18 (a) Funeral director Frank H Seitz
(b) Address 2436 E.

19 (a) DEC 16 1947 (Date rec'd by registrar) (b) Evelyn Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Dec 1947, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Dec 1947 to 14 Dec 1947 and that I last saw her alive on 14 Dec 1947.

Immediate cause of death Shock &c Cerebro-Vas accident — Duration

Due to Amputation Rt Leg

Due to Gangrene of Rt Leg

Other Conditions Diabetes mellitus HCVD (Include pregnancy within 3 months of death)

Date of operation 12/13/47

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C. Materlon M.D.
Address WBGH. Date signed 12/14/47

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 58024

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 - 9th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 - 9th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHANNA YOUNGBAR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	WIDOW

6 (b) Name of husband or wife PIERCE YOUNGBAR
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 15-1864

8. AGE: Years	Months	Days	If less than one day
83	1	29	hr. min.

9. Birthplace GERMANY. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business —

FATHER
12. Name NOT KNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN.
15. Birthplace GERMANY

16 (a) Informant ANDREW YOUNGBAR
(b) Address 3706 - 9th St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 17-47 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM.
Location A. A. Co.

18 (a) Funeral director Bernard E. Hosh
(b) Address 121 E. West St.

19 (a) DEC 1[illegible] 1947 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER-14 1947 at 5 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947 to Dec-14 1947 and that I last saw h[illegible] alive on Dec-10 1947

Immediate cause of death	Duration
Cardiac Decompensation	
Pulmonary Edema	
Due to Arterio Sclerosis	
Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Latham
Address 320 Patapsco Ave Date signed 12/15/47

VS 130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 61

Registered No. 658025

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 West FAYETTE ST
(c) Hospital or institution: None 201
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 81 yrs. 9 mos (Plus)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 W. FAYETTE ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Louisa Wilhemina Yost

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband ~~or wife~~ ① John C. Yost (D John Born)
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) MARCH 6, 1866
8. AGE: Years 81 | Months 9 | Days 8 | If less than one day — hr. — min.
9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business own home

FATHER
12. Name William Wichman
13. Birthplace GERMANY

MOTHER
14. Maiden Name Wilhemina Abbis
15. Birthplace GERMANY

16 (a) Informant Miss Grace Born (DAUGHTER)
(b) Address 2022 W. FAYETTE ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory MT Olivet
Location Baltimore

18 (a) Funeral director Fred H. Cole
(b) Address 1900 W Lanvale St

19 DEC 16 1947 Huntington Williams, M.D. (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1947, at 11.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1946, to December 14 1947, and that I last saw her alive on December 14 1947.

	Duration
Immediate cause of death Chronic myo-carditis & myocardial degeneration,	unknown
Due to Arteriosclerosis	unknown
Due to	
Other Conditions ① Diabetes Mellitus ② Chronic Arthritis (Include pregnancy within 3 months of death)	① 20 yrs ② 20 yrs
Date of operation	
Major findings of operation:	
of autopsy: —	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin N. Bordeau M. D.
Address 2030 W. Fayette St Date signed 12/15/47

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G58026

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4812 Frederick Ave
(c) Hospital or institution: 28.4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4812 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Cullen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Edward Cullen 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/30/1873

8. AGE: Years	Months	Days	If less than one day
74	6	16	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Patrick McConnell
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Carlin
15 Birthplace Ireland

16 (a) Informant Miss M. McNamara
(b) Address 4812 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director J. F. Tabler & Sons
(b) Address 1318 Light St.

19 (a) DEC 16 1947 (b) Registrar's signature for Williams Mills Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/47 19..., at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1946, to 12/15 1947 and that I last saw her alive on 12/13/1947.

	Duration
Immediate cause of death Uremia	7 Days
Due to Glomerulonephritis	15 yrs.
Due to Hypertension & Myocarditis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas Smith Jr. M. D.
Address 1737 E. Baltimore St Date signed 12/15/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 658027

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayerdale + Dudley
(c) Hospital or institution: WBGH 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 E. 27th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME NORA Anna Mae Dugan

3 (b) If veteran, name war

3 (c) Social Security Account No. 438-01-0748

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife W. J. Dupont

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1909

8. AGE: Years	Months	Days	If less than one day
38	5	15	hr. min.

9. Birthplace Balt. Md. (Town, county, and state)

10. Usual Occupation Clerk - Nat. Armaments

11. Industry or business

FATHER
12. Name HOWARD GROVE
13. Birthplace MD.

MOTHER
14. Maiden Name HARRIET FOUCHET
15. Birthplace [illegible]

16 (a) Informant MR. W. J. DUPONT
(b) Address 429 E. 27TH ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-47 (month) (day) (year)
(c) Cemetery or crematory
Location NEW ORLEANS. LA.

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) DEC 16 1947 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/1947 at 8:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19/1947 to 12/15/1947 and that I last saw her alive on 12/15/1947

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary sclerosis	
Due to Chronic hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy 12/15/47 (Contributes findings)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Gow M. D.
Address WBGH Date signed 12/16/47

VS 150

GRAY X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G58028

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cora B. Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1891

8. AGE: Years 56 | Months 5 | Days 19/20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Baltimore Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Claus Agers
13. Birthplace Bismarck

MOTHER 14. Maiden Name Frances Spalker
15. Birthplace —

16 (a) Informant Hoopt. Records
(b) Address No. Gen'l. Hoopt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Garrett Mount Apt. 22 No. St.

19 (a) DEC 16 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1947, at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1947, to Dec. 16 1947, and that I last saw her alive on Dec 15 1947.

	Duration
Immediate cause of death Uremia	
Due to Renal Failure	
Due to	
Other Conditions Hypertensive vascular Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund Burkhart M.D.

Address Md. Gen'l Hosp. Date signed 12/16/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 658029

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3926 Echo Dale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3926 Echo Dale Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME M. Elizabeth Flynn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, (married) widowed, or divorced. married

6 (b) Name of husband or ~~wife~~ William J Flynn Sr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-8-1878

8. AGE: Years 69 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business Mc Donough

FATHER
12. Name John J McDonough
13. Birthplace Md

MOTHER
14. Maiden Name Jean J Scott
15. Birthplace Md.

16 (a) Informant William J Flynn Sr.
(b) Address 3926 Echo Dale Ave

17 (a) Burial (b) Date thereof 12-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Fredrick Rd.

18 (a) Funeral director John A Mowan
(b) Address 3000 E Baltimore St.

19 (c) 12-16-1947 Huntington Williams M.D.
(Date) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15, 1947, at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1945 to 12/15 1947, and that I last saw h[er] alive on 12/2 1947

Immediate cause of death Arteriosclerotic Heart Disease — Duration 2 yrs

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis V. Blum, M.D.
Address 2910 Eutaw Pl. Date signed 12/15/47 M.D.

X

G5 8039 Dr. Peake

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No. G5 8039

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4639 Harcourt Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4639 Harcourt Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard A. Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Ida C. Kennedy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1883

8. AGE: Years	Months	Days	If less than one day
64	7	0	hr. min.

9. Birthplace Oakland, California (Town, county, and state)
10. Usual Occupation Marintime Commission
11. Industry or business Marine Surveyor

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Ida C. Kennedy
(b) Address 4639 Harcourt Road,

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12-18-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) DEC 16 1947 (Date rec'd by registrar) (b) Certificate for Williams MD

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14th, 1947, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 12-14 1947.
and that I last saw h[illegible] alive on 12-11 19 47.

Immediate cause of death Carcinoma of Stomach — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 5-23-47

Major findings of operation: Inoperable Ca Stomach

of autopsy: Impossible

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4508 Harford Rd Date signed 12-15-47

X

Dr. Gordy

C58031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C58031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3318 Lerch Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3318 Lerch Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Griffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife Edward C. Griffin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1869

8. AGE: Years	Months	Days	If less than one day
78	0	13	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Philip Brenneis
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Freund
(b) Address 3318 Lerch Drive, 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (d) DEC 16 1947 (Date rec'd by registrar) (b) Huntington Hollins, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14th, 1947 at 7.6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1947 to Dec 14 1947. and that I last saw her alive on Dec 11 1947

Immediate cause of death	Duration
Chronic myocarditis	2 years
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence — at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. Gordy M.D.
Address 5106 Harford Rd Date signed 12/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. C58032

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County Lancaster
(c) City or town [redacted] Lancaster Co. Penna.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 west Walnut St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Sue Groff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1947

8. AGE: Years | Months: 1 | Days: 17 | If less than one day: hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mr. A. Lloyd Groff
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Amanda A. Gish
15. Birthplace Pennsylvania

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19, 1947 (month) (day) (year)

(c) Cemetery or crematory New Holland
Location New Holland, Pa.

18 (a) Funeral director Paul Eshenbach
(b) Address New Holland, Pa.

19 DEC 17 1947 (Date rec'd by registrar) (b) Huntingtown Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17-1947 19 , at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1947 to Dec 17 1947, and that I last saw h alive on 19

Immediate cause of death Hydrocephalus
2 marked Cortical atrophy

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ira T. Dassen, M. D.

Address Date signed

658033

658033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 N Chester St
(c) Hospital or institution: 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 N Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Eckert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Christian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 1861

8. AGE: Years 86 | Months 3 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Johnson

13. Birthplace Germany

MOTHER 14. Maiden Name Johnson

15. Birthplace Germany

16 (a) Informant Emma Coffey

(b) Address 2403 Garden St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Baltimore Md

18 (a) Funeral director Wilhoyte & Son

(b) Address 1219 E Fort Ave

19 DEC 17 1947 (Date rec'd by registrar) (b) Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1947 at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947 to Dec 16 1947 and that I last saw h alive on Dec 16 1947

Immediate cause of death Chronic Myocarditis

Duration: 5 mos

Due to

Due to

Other conditions Arteriosclerosis and Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address 112 W. Saratoga St Date signed Dec 16-47

VS 150

937

G55034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183B

G55034 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2624 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2624 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Shutt

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Thomas W. Shutt, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 10, 1877

8. AGE: Years 70 | Months 5 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: John Meyers
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Elizabeth Gahs
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Thomas Shutt, Jr.
(b) Address: 3 W. Franklin Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/18/47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) DEC 17 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Dec 15 1947 and that I last saw her alive on Dec 15 1947.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Cerebral Thrombosis	7 days
Due to	
Other Conditions Arteio-Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed Dec 16-47

X

G58035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G58035

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CATHERINE SAWYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Separated

6 (b) Name of husband or wife Shelton Sawyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2nd 1895

8. AGE: Years	Months	Days	If less than one day
52	0	13	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Morris Elwood
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Delton
15. Birthplace Harford County, Maryland

16 (a) Informant Joseph Sharby
(b) Address 426 E. Lorraine Ave

17 (a) Burial (b) Date thereof 12/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Texas Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 12/17/47 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15, 1947, at 8:15 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [x], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Respiratory Failure

Due to uremia

Other Conditions Uremia

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Leah Rogen M.D.
Medical Examiner
Date signed 12-16-47

VS 181

X

over

458038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 58036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 W. Ostend St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Mansal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence M. Disser-Beckert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1884

8. AGE: Years 63 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Albert F. Thornton

13. Birthplace Balto Md

MOTHER 14. Maiden Name Mary L. Warfield

15. Birthplace Balto Md.

16 (a) Informant Charles L. Disser, Jr. (Son)
(b) Address 2012 Byrd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17, 1937 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location B. O. Co. Md

18 (a) Funeral director Thos. Evans
(b) Address 1400 E. Chase St Balto Md

19 (a) DEC 13 1937 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Tuesday Dec. 14 1937 at 1:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1, 1937 to Dec 14 1937 and that I last saw h- alive on Dec 1937

Immediate cause of death: Coronary Thrombosis — Duration 2 hrs

Due to Senile Nephrosclerosis — 2 yrs

Due to Arteriosclerosis — 4 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. T. Dowling
Address 1 E. Randall St Date signed 12/16/37 M. D.

VS 150

658037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓ 658037 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days) 10 D

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 W. 36th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Fox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed or divorced~~ Separated

6 (b) Name of ~~husband~~ or wife Ethel Tucker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county and state)

10. Usual Occupation Textile Spinner

11. Industry or business Mt. Vernon Mills

FATHER 12. Name Robert Fox

13. Birthplace Lynnville

MOTHER 14. Maiden Name Susan Moser

15. Birthplace Tenn

16 (a) Informant Mrs. H. E. Ingenmell (sister)

(b) Address Salem, S. C.

17 (a) Burial, cremation, or removal (b) Date thereof 12/17/47 (month) (day) (year)

(c) Cemetery or crematory Salem

Location S. C.

18 (a) Funeral director Williams-Cook Inc.

(b) Address 1217 St Paul St.

19 (a) DEC 17 1947 (Date rec'd by local registrar) (b) Huntington Williams Md (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/47 19 at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John L. Davis M.D. (Medical Examiner)

Date signed 12/13/47

VS 151

G58038

BC 2-96736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G58038 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution: West Balto. General Hosp 20-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41/2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 41/2 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 N. Pulaski St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Reed II

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-10-47

8. AGE: Years	Months	Days	If less than one day
		1	17½ hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Carroll J. Reed
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Wright
15. Birthplace Baltimore, Md.

16 (a) Informant Mary E. Reed - mother
(b) Address 525 N. Pulaski St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) 15 (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 15 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) DEC 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11/47 19 , at 7 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 12/10/47 19 to 12/11/47 19 , and that I last saw H alive on 12/11/47 19

Immediate cause of death	Duration
Resp. Failure	
Due to Prematurity	
Due to Atelectasis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: No
of autopsy: Autopsy at a later date

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. Waldrop
Address WBGH Date signed 12/11/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

For City Disposal
Bc# J-86333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registered No. G58039

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution: University Hospital 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4 MO.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N Pine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Montebello Norman Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	3	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/11/47

8. AGE: Years	Months	Days	If less than one day
	4	29	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Montebello Brown
13. Birthplace Md.

MOTHER 14. Maiden Name Eleanor White
15. Birthplace Va

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 15
(c) Cemetery or crematory
Location University Medical School DEC 1947

18 (a) Funeral director
(b) Address

DEC 17 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1947 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1947 to 12-10 1947, and that I last saw him alive on 12-10 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Malnutrition & Marasmus & Acidosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Mansbuger Jr M. D.
Address Univ. Hosp. Date signed 12-15

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G58040 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 S Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LUCY JENKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Clarence Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
29			hr. min.

9. Birthplace Ruffin S.C. (Town, county, and state)
10. Usual Occupation maid
11. Industry or business Hospital

FATHER
12. Name Bryant
13. Birthplace S.C.

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Clarence Jenkins
(b) Address 216 S. Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19-47 (month) (day) (year)
(c) Cemetery or crematory Ruffin S.C.
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W. Pratt St

19 (a) DEC 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1947, at 7.35 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull.
Fractured facial bones.
Due to Fractured ribs
Fractured clavicle

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-15-47 at 7.45 A.M.
(b) Where did injury occur? Pratt & Hopkins Place
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck by truck

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/15/47

X

G58041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G58041

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Pk. Heights Ave
(c) Hospital or institution: Mt Sinai Home 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mt Sinai Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNIE ABRAMS

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife: ISAAC
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant BENJ. ABRAMS
(b) Address 5814 NARCISSUS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-17-47 (month) (day) (year)
(c) Cemetery or crematory HERRING RUN
Location PHIL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PL.

19 DEC 17 1947 (Date rec'd by registrar) (b) Interring for Williamsport, Md.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16 1947 at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1945 to Dec. 15 1947 and that I last saw h[illegible] alive on Dec. 15th 1947

Immediate cause of death	Duration
Chronic Nephritis	2 yr.
Chr. Myocardial Degeneration	
Due to Chr. arterio-Sclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. G. Michelsen M. D.
Address 2230 Eutaw Pl. Date signed 12/16/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B58012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 658012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 166
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 wks 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No) If yes, name country .....

3 (a) FULL NAME Aubrey B. ~~Mayer~~ Minor

3 (b) If veteran, name of war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs. Adelaide
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) May 31, 1881
8. AGE: Years 66 | Months 6 | Days 14/5 | If less than one day ..... hr. ..... min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Insurance Salesman
11. Industry or business Life Ins. Co. of Virginia

FATHER
12. Name Henry C. Minor
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Minor
15. Birthplace Va.

16 (a) Informant Mrs. M. Adelaide Minor
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Balto. Md.
18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves. Balto. Md.
19 (a) Dec 17 1947 (Date rec'd by registrar) (b) Huntington Ave. Baltimore Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 19 47, at 11:30 M
21. I certify that death occurred on the date above stated; that I attended deceased from August 8 19 47 to Dec. 15 19 47 and that I last saw h[illegible] alive on 12-15 19 47.

Immediate cause of death Metastatic Carcinoma of vertebral Column & Compression of cord — Duration
Due to Bronchogenic Carcinoma
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury —
23. Signature John A. Nightower M. D.
Address University Hosp. Date signed 12-15-47

X

658043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

658043 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3923 W. Mulberry st.
(c) Hospital or institution: 20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3923 W. Mulberry street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: George Henry Bafford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Ann Bafford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1872

8. AGE: Years	Months	Days	If less than one day
75	10	2	hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Alexander Bafford
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs. Geo. Andrew Bafford
(b) Address 3923 W. Mulberry st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetary
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 DEC 17 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1947 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24, 1942 to Dec. 14, 1947 and that I last saw him alive on Dec. 12, 1947

Immediate cause of death	Duration
Pulmonary hemorrhage	1 day
Due to Cronic pulmonary tuberculosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leopold Krupp M. D.
Address 303 Edmondson Ave. Date signed 12/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58044 | Registered No. G58044

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1201 Valley St
(c) Hospital or institution: Home for the Aged + Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophie O'Neill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	M.

6 (b) Name of husband or wife Michael O'Neil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1883

8. AGE: Years	Months	Days	If less than one day
64	1		hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Green
13. Birthplace

MOTHER 14. Maiden Name Mary Sanders
15. Birthplace

16 (a) Informant Gilla Linton Jr. Rel
(b) Address 1201 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Rd

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

19 DEC 19 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1947, at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 - 1947 to Dec 15 1947, and that I last saw her alive on Dec 15 1947.

Immediate cause of death	Duration
Edema Lungs	1 Day
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions Arterio-Sclerosis	4 yr

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. Monument Ave Date signed Dec 16-47

X

G58045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59a

Registered No. G58045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2223 Linden Ave.
(c) Hospital or institution: 13-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 Linden Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Elias

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mariam S. Elias
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25 1869

8. AGE: Years	Months	Days	If less than one day
78	5	21	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Retired Salesman
11. Industry or business

FATHER
12. Name ? Elias
13. Birthplace Germany.

MOTHER
14. Maiden Name Mary Sundheim
15. Birthplace Germany

16 (a) Informant Mr. Horace J. Elias
(b) Address 2223 Linden Ave.

17 (a) Burial (b) Date thereof 12/18/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sundheim & Son
(b) Address 1907 Eutaw Place

19 (a) DEC 17 1947 (b) Registrar for Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16/1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1941 19 to 12/16 1947.
and that I last saw h alive on 12/16 1947.

Immediate cause of death	Duration
Cardiac dilatation	
Due to Pneumonia	
Due to	
Other Conditions Abruptio arthritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. O. Ludeman
Address 2220 Linden Ave Date signed 12/16/47

VS 150

109

658046 ✓ 658046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw Place & Wilson St. Marlborough Apts. 14-1
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN FRANK.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Bertha Frank.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1855.

8. AGE: Years	Months	Days	If less than one day
92	2	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Scrap Material Merchant.
11. Industry or business

FATHER
12. Name Nathan Frank,
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown,
15. Birthplace Germany.

16 (a) Informant Mrs. Bertha Frank,
(b) Address Marlborough Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.18.47. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1902 Eutaw Place.

19 DEC 17 1947 (Date received by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1947, at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to Dec. 16 1947 and that I last saw h[illegible] alive on Dec. 15, 1947.

Immediate cause of death Myocardial Insufficiency — Duration 1 week
Due to Arteriosclerosis
Due to
Other Conditions Bronchopneumonia — 1 week
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Isidor D. Levy, M. D.
Address 2222 Eutaw Place Date signed 12/16/47

VS 150

G58017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G58017 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Jenkins Memorial 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.,
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Northern apts. Hoole & Bentz Rd
(If rural give location)
(e) Citizen of foreign country? " (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary a. Reddington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1868

8. AGE: Years 79 | Months 3 | Days 4 | If less than one day: hr. min.

9. Birthplace Ireland - Roscommon (Town, county, and state)

10. Usual Occupation ~~Patrick Reddington~~

11. Industry or business

FATHER 12. Name Patrick Reddington
13. Birthplace Ireland

MOTHER 14. Maiden Name Elizabeth Devine
15. Birthplace Ireland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 2220 East Biddle St

19 DEC 17 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 | 16 | 1947 at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1947 to 12/16 1947 and that I last saw h[illegible] alive on 12/14 1947.

Immediate cause of death Cardiac failure — Duration
Cerebral vascular accident
Due to Hypertension & OD
Due to Gen'l arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address 1 Azur Date signed 12/16/47

VS 150

658038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 315
(a) Baltimore City, Maryland
(b) Street address 15 NE Division St.
(c) Hospital or institution:
Provident 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 E Pearl St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel Cornell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe

5. Color or race: N

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: WILLIAM CORNELL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 24, 1911

8. AGE: Years: 36 | Months: 3 | Days: 23 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name FRANCIE RUGANT
13. Birthplace MD.

MOTHER
14. Maiden Name FLORENCE CAREY
15. Birthplace MD

16 (a) Informant ARETHA CORNELL
(b) Address 789 PRESTON ST. - W. PHILA. PA.

17 (a) Burial (b) Date thereof Dec 20 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Brantley Ave

19 (a) Dec 17 1947 (b) Huntington Williams, Md
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 19X2 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 19X7 to 12/16 19X2, and that I last saw h[illegible] alive on 12/16 19X2

Immediate cause of death	Duration
Subacute thyroid thrombosis	
Due to Hypertension	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Ranta Grant M. D.

Address 15 E 14 Division Date signed 12/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

658039 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3640 Falls Road
(c) Hospital or institution: 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3640 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Calvin Dasch

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-07-4641
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lillian Marie Dasch
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 22-1889
8. AGE: Years 58 | Months 5 | Days 23 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Foreman, Cutting Dept
11. Industry or business Knothe Brothers

FATHER
12. Name William Dasch
13. Birthplace Maryland

MOTHER
14. Maiden Name Edith Arthur
15 Birthplace Maryland

16 (a) Informant Mrs. Lillian M. Dasch
(b) Address 3640 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18-1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

DEC 17 1947 (Date Rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15. 1947, at 6 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 1947 to Dec. 1947 and that I last saw him alive on Dec. 15 1947

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Thrombosis	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. Knudsen M. D.
Address 216 W. Pratt Date signed 12/17/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

~~5380~~90 115490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 13B

Registered No. C58050

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME William Lyle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: seperated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June, 13- 1898

8. AGE: Years 49 | Months 5 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Lyle
13. Birthplace ?

MOTHER 14. Maiden Name Rosie ?
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location a. a County Md

18 (a) Funeral director Mrs. Robt a. Elliott
(b) Address 1129 N. Caroline St

19 (a) DEC 17 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12- 1947, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1947, to 12-12 1947, and that I last saw h im alive on 12-12 1947.

Immediate cause of death Tuberculosis of Lungs, Bilateral, far advanced — Duration 1 yr

Due to

Due to

Other Conditions Spontaneous pneumothorax + empyema
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

BJ Hubbs
PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Beagle W. Parks M. D.
Address Bal City Hosp Date signed 12-15-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E 58051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 33a

Registered No. 058051

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 Rutland Ave
(c) Hospital or institution: N.H.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 931 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Harry H. Waddy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Widower

6 (b) Name of husband or wife Hannah B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1890

8. AGE: Years	Months	Days	If less than one day
57	2	28	hr. min.

9. Birthplace Northumberland Co. Va
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Waddy
13. Birthplace Va.

MOTHER
14. Maiden Name Eliza Davenport
15. Birthplace Va.

16 (a) Informant Beatrice Reid
(b) Address 931 Rutland

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 17 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Baltimore Co. Md

18 (a) Funeral director Mrs Lottie Williams
(b) Address 1129 N. Carolina St

19 (a) DEC 17 1947 (Date rec'd by registrar) (b) Huntingtown Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1947, at 1:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1947 to 12-14 1947, and that I last saw h alive on 12-13 1947.

Immediate cause of death	Duration
Bronchopneumonia	1 week
Due to Chronic laryngo-bronchitis & Hiatus	3 weeks
Due to	
Other Conditions Hypotension	10 wks

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature D. W. McDaniel M. D.
Address 802 N Carolina St Date signed 12-14-47

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

C58052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ X C58052 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Upperco
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD CONCANON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Maried

6 (b) Name of husband or wife Mary M (nee Wilhelm)
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July 25, 1875

8. AGE: Years	Months	Days	If less than one day
72	4	21	hr. min.

9. Birthplace Harford Co., Md
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business dairy

FATHER
12. Name Edward Concannon
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Mary Connon
15. Birthplace Balto Co, Md

16 (a) Informant Mrs. Edward Concannon
(b) Address Whitehall, Md.

17 (a) Burial (b) Date thereof Dec. 19, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Texas, Maryland

18 (a) Funeral director Lawrence M. Bruce
(b) Address Govans, Md.

DEC 17 1947 (b) Timothy Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1947, at 6.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock due to
Compound fractures of both
Tibia + Fibulae
Due to Fractures of Pelvis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-16-47 at 4.30 P.M. Balto. Co.
(b) Where did injury occur? Hanover Rd. above Arcadia Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by auto

23. Signature Carl L Yingling M.D.
Medical Examiner
Date signed 12-17-47

X

G58053

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 13a

G58053
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 639 Jasper st. 17-1
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 639 Jasper st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elliott Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1895

8. AGE: Years 52 | Months 2 | Days 12 | If less than one day ____hr. ____min.

9. Birthplace Dowings Virginia
(Town, county, and State)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Lewis
13. Birthplace Dowings, Va.

MOTHER
14. Maiden Name Copeland
15. Birthplace Dowings Va

16 (a) Informant Lillie Neall (sister)
(b) Address 1032 N. Gilmor St

17 (a) Burial (b) Date thereof 12-17-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. K. R. Willing
(b) Address 322 N. Schroeder St

DEC 19 1947 Huntington Williams, Registrar
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1947, at 6:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1947 to 12/13 1947 and that I last saw h/e alive on 12/10 1947

Immediate cause of death: Hypertension C-V Renal Disease — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M. D.

Address 1614 Division Date signed 12/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G58054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G58054 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: PROVIDENT HOSPITAL 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 W. Lafayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES BLAND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1896

8. AGE: Years 51 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Chemist Asst

11. Industry or business

FATHER
12. Name Unknown Bland
13. Birthplace "

MOTHER
14. Maiden Name Mary Jones
15. Birthplace N.C.

16 (a) Informant Mary Blunt
(b) Address 1224 W. Lafayette Ave

17 (a) Burial (b) Date thereof Dec. 20, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St
Funeral Director for Williams, M.D.

19 (a) DEC 22 1947 (b)
(Date received by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1947 at 4.45 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of lung

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-10048 658055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 658055 Registered No. 92a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 53yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Madeira St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Casimir Glowinski-or-Casimir Glowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Annie-Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14- 1877

8. AGE: Years 70 | Months 10 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Lee Glowinski-or-Lee Glowski(D
13. Birthplace Poland

MOTHER
14. Maiden Name Mabel or Mahl ? (D
15. Birthplace Poland

16 (a) Informant Records-Baltimore City Hospita
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18th 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lea G. Leach
(b) Address 1701-03 N. Patterson Park ave

DEC 17 1947 (Date received by Registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 19 47, at 10.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9- 19 46 to 12-15 1947, and that I last saw h in alive on 12-15 1947

Immediate cause of death Cardiac failure - sudden — Duration

Due to Aortic stenosis

Due to Arteriosclerotic Cardio-renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Knabe M. D.
Address Balto City Hosp. Date signed 16 Dec 47

VS 150

X

AB-115850 G58056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 61

G58056 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 7-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 McKldorry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Grace Geary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12-1907

8. AGE: Years	Months	Days	If less than one day
40	11	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Geary (D
13. Birthplace Maine

MOTHER
14. Maiden Name Ada Keys
15. Birthplace Baltimore, Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec 19th 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Gaylor Ave

18 (a) Funeral director Leo Gudesoth
(b) Address 1201-03 N. Patterson Park ave

19 (a) Huntington Williams M.D.
(Date rec'd by registrar)

DEC 19 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16- 19 47 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12- 19 47 to 12-16- 19 47, and that I last saw h. or alive on 12-16- 19 47.

Immediate cause of death	Duration
Coronar Failure	
Due to Rheumatic Cardio-vascular Disease.	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Autopsy.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vastine
Address Balto City Hosp Date signed 16 Dec 47
M.D.

93c

G58057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G58057

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Mulliken Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Mulliken Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie McClain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30. 1901

8. AGE: Years	Months	Days	If less than one day
42	5	13	hr. min.

9. Birthplace Potecasi N. C.
(Town, county, and state)

10. Usual Occupation Bench Hand

11. Industry or business Western Electric

FATHER 12. Name Glover Fentrella

13. Birthplace North Carolina

MOTHER 14. Maiden Name Henrietta Grant

15 Birthplace North Carolina

16 (a) Informant Helen Dixon

(b) Address 1601 Mulliken Court

17 (a) Burial (b) Date thereof Dec. 17, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1110 Bridgeland

DEC 17 1947
(Date rec'd by registrar) (b) Registrar

Burlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

Dec. 13 4:40 PM

20. DATE OF DEATH Dec 13 1947, at 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1947, to Dec 13, 1947, and that I last saw h[illegible] alive on Dec 13 1947.

Immediate cause of death	Duration
Squamous Cell Carcinoma	
of left Breast	8 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.

Address 807 N. Carolina St. Date signed 12-15-47

TO BE APPROVED.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658058 — BALTIMORE CITY HEALTH DEPARTMENT — 658058 Registered No.

CERTIFICATE OF DEATH 121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline 12-2
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Calvert Court apts (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Robert Graham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dorothy Miller Graham | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/15/88

8. AGE: Years 59 | Months 10 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Relay, Md. (Town, county, and state)

10. Usual Occupation insurance adjuster

11. Industry or business

FATHER — 12. Name John R. Graham
13. Birthplace Md.

MOTHER — 14. Maiden Name Margaret ?
15. Birthplace Md.

16 (a) Informant Mrs. Dorothy Graham
(b) Address Calvert Court Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery ~~the crematory~~ Springfield
Location Sykesville, Md.

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) DEC 17 1947 Date rec'd by registrar (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/47 19____, at ____M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17/47 19____ to 12/17/47 19____, and that I last saw h Live alive on 12/17/47

Immediate cause of death	Duration
Cardio-Respiratory failure	
Cerebral-Vascular Accident	
Due to Arteriosclerosis	
Due to Acute Suppurative Appendicitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12/17/47
Major findings of operation: Acute Suppurative Appendicitis
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mytleya A Binkley M.D.
Address 1400 Caroline Date signed 12/17/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G58059 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-7
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 W. University Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert H. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Jennie H. Homan

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1876

8. AGE: Years	Months	Days	If less than one day
71	1	14	hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation Retired Lawyer.

11. Industry or business

FATHER
12. Name John W. Williams
13. Birthplace Md

MOTHER
14. Maiden Name Pamelia Hope
15. Birthplace Md.

16 (a) Informant Robert H. Williams Jr.
(b) Address 702 W. University Pky.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemy.
Location Woodlawn, Md.

18 (a) Funeral director John S. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) DEC 17 1947 (Date rec'd by registrar) (b) Lexington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16- 1947 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16 1947 to 12-16 1947, and that I last saw h/ alive on 12-16 1947

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. B. Mayer M. D.
Address Univ. Hosp Date signed 12-16-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58060 — BALTIMORE CITY HEALTH DEPARTMENT — G58060 Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway 11-3
(c) Hospital or institution: (Balt Md) Church Home & Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842 Park Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Joan Soup JOAN F. SOOP

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?
8. AGE: Years 69? Months Days If less than one day hr. min.
9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business none

FATHER
12. Name Frank Soup
13. Birthplace New York

MOTHER
14. Maiden Name Anna McCarthy
15. Birthplace Ireland

16 (a) Informant Chas. Wm. Soop
(b) Address 842 Park Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemy.
Location Pikesville, Md
18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Pl.
19 (a) DEC 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1947, at 4:00 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1947, to Dec 16 1947, and that I last saw h.er alive on Dec 14 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic Heart Disease, Coronary Occlusion	
Due to	
Other Conditions Pulmonary Edema - Myocardial Degeneration	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph D'Antonio M. D.
Address Date signed

X

G58061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

✓ G58061 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2836- Alemada Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORA E. HEBDEN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: Alfred S. Hebden
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 20, 1869
8. AGE: Years 78 | Months 3 | Days 25 | If less than one day ... hr. ... min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name: Thomas J. Wills
13. Birthplace: Balto.

MOTHER
14. Maiden Name: Alice J. Barranger
15. Birthplace: Ohio

16. (a) Informant: Dorothy Orr
(b) Address: 405 Jefferson St. Alex. La.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18/47 (month) (day) (year)
(c) Cemetery or crematory: Green Mount Cem
Location: Greenmount Ave & Oliver
18 (a) Funeral director: John O. Mitchell & Son
(b) Address: 1900 Eutaw Place
19 (a) 1947 (Date filed by registrar) (b) [illegible] Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15, 1947, at 9.35P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage, Rt.

Due to Fracture 2nd & 3rd ribs Rt.

Other Conditions Fract. Rt. Humerus
Generalized A S C U Disease
(Including pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 9/3
(a) Date of injury 12-15-47 at about 9 P. M.
(b) Where did injury occur? 33rd & Alemada Blvd. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by auto

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

658062 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 Frederick Avenue
(c) Hospital or institution: 20-S
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Orpha Helen Stenner

3 (b) If veteran, name war None | (c) Social Security Account No. None

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry Stenner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/1880

8. AGE: Years 67 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Detroit, Michigan (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Home

FATHER 12. Name Unknown
13. Birthplace Michigan

MOTHER 14. Maiden Name Unknown
15. Birthplace Michigan

16 (a) Informant Henry Stenner
(b) Address 2119 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Johnson
(b) Address 2101 Frederick Ave.

DEC 17 1947 (Date rec'd by registrar)

(a) (b) Registrar

Huntington Williams, M.D.

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1947, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5. 1947 to Dec. 15 1947. and that I last saw her alive on Dec. 15. 1947.

Immediate cause of death	Duration
Chronic Interstitial Nephritis	5 yrs.
Due to Cardiac Dilatation	2 da.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard J. Blake M. D.
Address Med. Arts Bldg Balto Date signed 12-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

G58063
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 246 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES MANCINI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Celia Mancini
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1900

8. AGE: Years	Months	Days	If less than one day
47 45	6	22	hr. min.

9. Birthplace Rotella Italy
(Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry or business Beth. Steel Co.

FATHER
12. Name Giuseppe Mancini
13. Birthplace Italy

MOTHER
14. Maiden Name Nazzarena
15. Birthplace Italy

16 (a) Informant Celia Mancini (wife)
(b) Address 246 S. Clinton St.

17 (a) Burial (b) Date thereof Dec. 19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) DEC 17 1947 (b) Huntingtown Maryland
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1947, at 12.50 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull with intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-16-47 Found: 53 12: A.M.
(b) Where did injury occur? (Found) Pattison Pk. Ave & Patterson Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Blunt Force

23. Signature Earl L. Kruger M.D.
Medical Examiner
Date signed 12-16-47

X

Dr. L. Brill
1221 N. Lu~~658064~~

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

Registered No. G58064

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1740 East Chase Street
(c) Hospital or institution: 4-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1740 East Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELZA RAY DEFFINBAUGH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1892

8. AGE: Years	Months	Days	If less than one day
55	6	12	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Deffinbaugh
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Louise Sliger
15. Birthplace Pa.

16 (a) Informant Mr. John Deffinbaugh
(b) Address 5903 Arabia Avenue, 14

17 (a) Burial (b) Date thereof 12-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14
19 (a) DEC 16 1947 Washington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15th, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1947 to Dec. 15 1947, and that I last saw him alive on Dec 12 1947

Immediate cause of death Carcinoma of Liver — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lyman Brill M. D.
Address 1221 N. Luzon Ave Date signed Dec 16 1947

V S 150

Transcript #058065 BALTIMORE CITY HEALTH DEPARTMENT ✓ 058065
CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 Inc Kean Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Inc. Kean Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Minnie Ida Neiswender

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James G. Neiswender
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25- 1879

8. AGE: Years 68 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Schuylkill Co. Penna.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name Wm. Evans
13. Birthplace Penna.

MOTHER 14. Maiden Name Ida Rowe
15. Birthplace Penna.

16 (a) Informant James G. Neiswender
(b) Address 1628 Inc. Kean Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19-1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Baltimore Cem.

18 (a) Funeral director Eugene C. Lefler
(b) Address 1600 W. North Ave

19 (a) (Date received by registrar) (b) Registrar
DEC 17 1947
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1947, at 9-20 A.M. P.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15-47 19 to 12-15-47 19; that I last saw alive on 12-15-47; and that death occurred at 9-20 A.M.

Immediate cause of death: Cerebral Hemorrhage
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 2 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature N. C. Stanworth M.D.
Address 6711 Main St. Date signed 12-16-47

X

G58966 Amended BALTIMORE CITY HEALTH DEPARTMENT Registered No. G58066

CERTIFICATE OF DEATH

159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Patapsco Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Guzzi

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-6-47

8. AGE: Years	Months	Days	If less than one day
		X	18 hr. 2 min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Mary Ann Guzzi
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School DEC 12, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1947, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1947, to Dec 7 1947, and that I last saw her alive on Dec 7 1947.

Immediate cause of death Prematurity — Duration 1 day
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Beaver M.D.
Address Johns Hopkins Hosp Date signed 12-8-47

X

658067 B6" 2-91936

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160 c

Registered No. 658067

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Tishler

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	wht	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 28, '47

8. AGE: Years	Months	Days	If less than one day
NB			4 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Eli Tishler
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Exler
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ann Tishler
(b) Address 2210 Baker St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School DEC 12, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 17 1947 (Date rec'd by Registrar) (b) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28, 1947 19 at 8:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28/ 19 47 to 11/28/ 19 47 and that I last saw h im alive on 11/28/ 19 47

Immediate cause of death: Pulmonary
Due to ?
Due to
Other Conditions Ruptured Cord
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. O. Goldstein M. D.
Address Sinai Hospital Date signed 12/2/47

X

State Anatomical 43141 Bc 4-[illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 658068

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparks (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby (Esther) Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	col.	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/27/47

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Richard Powell
13. Birthplace Md.

MOTHER
14. Maiden Name Esther Powell Dyett
15. Birthplace Md.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical School DEC 12 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (Date rec'd by Registrar) Committed for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-5- 1947, at 11 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27- 1947 to 12-5- 1947 and that I last saw her alive on 12-5- 1947.

Immediate cause of death	Duration
Intracranial Hemorrhage	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature [illegible]
Address Johns Hopkins Hosp. M. D. Date signed 12-6-47

VS 150

658069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

658069
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2085 DRUID PARK DR.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2085 DRUID PARK DR.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OMA BROYLES

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife CHARLES L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1879

8. AGE: Years	Months	Days	If less than one day
68	7	0	hr. min.

9. Birthplace MONROE Co. W. Va.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name HENRY SMITH
13. Birthplace MONROE Co., W. Va.

MOTHER
14. Maiden Name MARY JOHNSIDT
15. Birthplace MONROE Co., W. Va.

16 (a) Informant MRS IDA WARD
(b) Address 2085 DRUID PARK DR. Balto., Md.

17 (a) Removal (b) Date thereof 12-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BROYLES CEM
Location PETERSTOWN, W. Va

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto. 17, Md.

19 (a) Huntington Williamson, W. Va. (b)
(Date received by registrar) Registrar

DEC 17 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 16 1947, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to Dec 16 1947, and that I last saw her alive on Dec 16 1947.

Immediate cause of death Coronary Thrombosis — Duration 1-2 yrs

Due to Advanced Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Ramsey M. D.

Address 642 North Blvd Date signed 12-17-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65870 | BALTIMORE CITY HEALTH DEPARTMENT | 65870 Registered No.

CERTIFICATE OF DEATH

1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town York (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 W Poplar St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Irvie S. Smith

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.
(b) Name of husband or wife: Warren Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 30 1895

8. AGE: Years 52 | Months 3 | Days 16 | If less than one day: hr. min.

9. Birthplace Wrightsville, Pa (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Irvin S. Kline
13. Birthplace York Co. Pa

MOTHER
14. Maiden Name Maggie Gohn
15. Birthplace York Co Pa

16 (a) Informant Hospital Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory
Location York Pa.

18 (a) Funeral director Wm. J. Zieminskas
(b) Address North Ave
(c) (Date rec'd by registrar) DEC 17 1947 (Signature for Address registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16-47 19 , at 11 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15-47 19 , to 12-16 19 , and that I last saw h[illegible] alive on 12-16-47 19 .

Immediate cause of death	Duration
Respiratory failure	
Due to Mediastinal compression	
Due to Cerebral Clot	
Cerebral Clot	
Other Conditions Hypertensive Cardiovascular Disease	

(Include pregnancy within 3 months of death)

Date of operation 12-15-47.
Major findings of operation: Clot
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Halsey M. D.
Address Univ Hosp Date signed 12-16-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1558071 443797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. 1558071

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITEL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4805 York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ~~William B. Krauk~~ William B. Krauk

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Louise R Krauk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-21-59

8. AGE: Years	Months	Days	If less than one day
88	10	25	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name William Krauk
13. Birthplace Germany

MOTHER
14. Maiden Name Maria
15. Birthplace Germany

16 (a) Informant
(b) Address OHNS HOPKINS HOSPITEL

17 (a) Burial (b) Date thereof Dec 18
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Cty

18 (a) Funeral director Sellers Funeral Home
(b) Address 2008 Orleans St

19 DEC 18 1947 (b) Huntington for Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 - 1947 at 11 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27- 1947 to 12-15- 1947 and that I last saw him alive on 12-15- 1947.

Immediate cause of death	Duration
Uremia	
Due to Arteriosclerotic nephritis	
Due to	
Other Conditions arteriosclerotic heart disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Victor A. McKusick M. D.
Address Johns Hopkins Hosp. Date signed 12/16

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58072

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G58072

CERTIFICATE OF DEATH 46a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. - 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Hannah Corse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

(b) Name of husband or wife: Mrs Hannah LOOSEMORE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-3-1878

8. AGE: Years	Months	Days	If less than one day
69 68	7	13	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Rees
13. Birthplace England

MOTHER
14. Maiden Name Mary Davis
15. Birthplace England

16 (a) Informant daughter - Mrs Hannah Loosemore
(b) Address 6527 Cleveland Ave. Balto.

17 (a) Burial (b) Date thereof Dec 20
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 DEC 18 1947 (b) Huntington Williamsport, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 December 1947, at 2 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1947 to Dec 16, 1947 and that I last saw her alive on Dec 16 1947

Immediate cause of death	Duration
Bronchopneumonia with cardiac failure	
Due to cachexia	
Due to carcinoma of esophagus with extension into the cardiac end of the stomach	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Nov. 29, 1947
Major findings of operation: Carcinoma of esoph. & extension into cardiac.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Fischer M. D.
Address Church Home Date signed 12-16-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

Registered No. 658073

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 Mc Alear Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Fortenbaugh

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1865
8. AGE: Years 79 | Months | Days | If less than one day ____hr. ____min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Michael Fortenbaugh
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Phillips
15. Birthplace Maryland

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19/47 (month) (day) (year)
(c) Cemetery or crematory St Matthews Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2118 Orleans St

19 (a) DEC 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1947 to Dec 16 1947 and that I last saw h[illegible] alive on Dec 16 1947.

Immediate cause of death	Duration
Cardiac failure	20 days
Due to Perforated peptic ulcer	20 days
Other Conditions	

(Include pregnancy within three months of death)
Date of operation 21 Nov 47
Major findings of operation Perforation of peptic ulcer
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A Baird Hoffman, M.D.
Address Johns Hopkins Hosp Date signed 16 Dec 47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58074 B.C.# 4-67973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

Registered No. G58074

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 26-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 3410 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JEROME DOUGLASS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17- 1943

8. AGE: Years	Months	Days	If less than one day
4	11/12	29	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Jerome Douglass
13. Birthplace Balto

MOTHER
14. Maiden Name Lillian Lewinski
15. Birthplace Balto

16 (a) Informant Jerome Douglass
(b) Address 3710 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Rosby

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 (a) Dec 19 1947 (Date rec'd by reg'r) (b) Thaddeus Jos Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15, 1947, at 2.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull &
intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26/8

(a) Date of injury 12-14-47 11 P. M.
(b) Where did injury occur? 3400 block E. Lombard St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Earl L Penny M.D.
Medical Examiner
Date signed 12-16-47

G58075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G58075

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: FRANKLIN SQUARE HOSPITAL 21-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1568- Ridgley St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME GEORGE G. DEEMS

3 (b) If veteran, name war: -----

3 (c) Social Security Account No. 215-10-6923

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorsed

6 (b) Name of husband or wife: -----

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 7th I895

8. AGE: Years 52 | Months 8 | Days 9 | If less than one day ..2.. hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name George W Deems
13. Birthplace Baltimore

MOTHER
14. Maiden Name Florence Purple
15. Birthplace Baltimore

16 (a) Informant Margaret Houck
(b) Address 2334 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof I2- I9 * 47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Edward Toulson
(b) Address 2359 Wash Blvd

19 (a) DEC 18 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1947, at 4.20 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis.
Edema of lungs.

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature George L Merrill M.D. Medical Examiner.
Date signed 12-17-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 058076

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 S. Parrish St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 S. Parrish st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Warfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 7th 1877

8. AGE: Years 70 | Months 11 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Huckster

FATHER
12. Name Columbus Warfield
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Taylor
15. Birthplace Md.

16 (a) Informant Elmer Smith
(b) Address 403 Parrish St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie, A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 18 1947 (Date received by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Dec. 1947 to 16 Dec 1947. and that I last saw him alive on 16 Dec 1947.

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Arteriosclerosis	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Baylus M. D.
Address 1600 Williams Ave Date signed 17 Dec 47

VS 150

G58077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G58077

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BALTIMORE CITY HOSPITAL 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE A. POWELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	217-07-1892

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1892

8. AGE: Years	Months	Days	If less than one day
55 SMT.	5	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business H. J. McGrath Company

FATHER
12. Name Orlando T. Powell
13. Birthplace N. Car.

MOTHER
14. Maiden Name Nanny B. Sledge
15. Birthplace N. Car.

16 (a) Informant Mrs. Mary R. Powell
(b) Address 109 N. Stricker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 18 1947 (Date rec'd by registrar) (b) Huntington Ave Williamsburg, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1947, at 6.10A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial hypertrophy and dilatation.
Edema of lungs
Passive congestion of all organs
Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 12-16-47

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C58078

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Barnsdale Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Barnsdale Blvd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Delia Eidman

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	

6 (b) Name of husband or wife Harry D. Eidman Jr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15-1871

8. AGE: Years	Months	Days	If less than one day
76	8	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Home-maker
11. Industry or business —

FATHER
12. Name John Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Ripley
15. Birthplace Germany

16 (a) Informant Ruth Eidman
(b) Address 2304 Barnsdale Blvd.

17 (a) Burial (b) Date thereof 12/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) DEC 18 1947 (b) Received by Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17- 1947, at 8:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 15 1935, to 12-17- 1947, and that I last saw h[illegible] alive on 12-15- 1947.

Immediate cause of death	Duration, a few minutes
Coronary Thrombosis	
Due to Hypertension	12 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Riland, M. D.
Address 2532 Edmondson Ave. Date signed 12-17-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C58079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 W. Hoffman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 635 W. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JEREMIAH McGEE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1 1879

8. AGE: Years	Months	Days	If less than one day
68	10	15	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jeremiah McGee
13. Birthplace N. C.

MOTHER
14. Maiden Name Annie Carter
15. Birthplace N. C.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) DEC 18 1947 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Dec 16 1947 and that I last saw him alive on Dec 16 1947.

Immediate cause of death	Duration
Cardiac Insufficiency	1 day
Anemia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M. D.
Address 5 M- Galveston Date signed 12/17/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G58080

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126 N. Poppleton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 N. Poppleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ULYSSES G. SORRELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife (Elizabeth) Sorrell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1876

8. AGE: Years	Months	Days	If less than one day
71	10	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Wm. Samuel Sorrell
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Ellen Snowden
15. Birthplace Howard Co., Md.

16 (a) Informant Mrs. (Elizabeth) Sorrell
(b) Address 126 N. Poppleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A? Hemsley
(b) Address 578 W. Biddle St.

19 (a) DEC 18 1947 (Date received by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Dec. 15, 1947, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1947 to Dec 15 1947 and that I last saw h[im] alive on Dec 15 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Hypertensive Cardio-vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Henry Glassman M. D.
Address 753 W. Lafayette Ave Date signed Dec 17, 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161

Registered No. G58031

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 E GRINDALL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 E. GRINDALL (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA MAY SCHELHAUSE

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife ELMER
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) SEPT. 17, 1897

8. AGE: Years	Months	Days	If less than one day
50	2	29	____ hr. ____ min.

9. Birthplace ROCK HALL, MD (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

MOTHER / FATHER
12. Name RICHARD HUDGES
13. Birthplace ROCK HALL, MD
14. Maiden Name — DOWNEY
15. Birthplace ROCK HALL, MD.

16 (a) Informant ELMER SCHELHAUSE
(b) Address 401 E GRINDALL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST. -30

19 (a) DEC 18 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 16, 1947, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 16 1946 to DEC 16 1947 and that I last saw h[illegible] alive on DEC 16 1947.

Immediate cause of death	Duration
acute Dilatation of heart	2 hrs
Due to diabetes Mellitus	[illegible]
Due to Arteriosclerosis	[illegible]
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. Campbell M. D.
Address 1644 Harlem St Date signed Dec 17, 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182a

658082 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BEATRICE MULHERN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1947

8. AGE: Years	Months	Days	If less than one day
	3	26	hr. min.

9. Birthplace ANNAPOLIS, MD. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name WILLIAM MULHEARN

13. Birthplace PENNSYLVANIA

MOTHER 14. Maiden Name LEONA SHINABERRY

15. Birthplace MT. ROAD. VA.

16 (a) Informant MR WILLIAM MULHEARN

(b) Address MAGOTHY BEACH RD. PASADENA MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)

(c) Cemetery or crematory GLEN HAVEN

Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.

(b) Address 715 LIGHT ST

19 (a) DEC 18 1947 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1947, at 6.30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical Suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12/17/47 at Pasadena, Md 6:30 a. M.

(b) Where did injury occur? Pasadena, Md

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no

(d) Means of injury Strangled by Rope

23. Signature [signature] M.D. Medical Examiner

Date signed 12-17-47

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58083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 58083

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1036 POPLAR GROVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE SPILMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	WIDOW

6 (b) Name of husband or wife JOHN F SPILMAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 25-186

8. AGE: Years	Months	Days	If less than one day
86	5	22	hr. min.

9. Birthplace BALTO - MD
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Not Known
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Walter Spilman
(b) Address 1036 Poplar Grove

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC 19-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Cook's Lane - Balto Co

18 (a) Funeral director Mrs Chas A G Reinder
(b) Address 2327 Edmondson Ave

19 (a) DEC 19 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 17 1947 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1930 to Dec 17 1947 and that I last saw her alive on Dec 15 1947.

	Duration
Immediate cause of death: cardiac failure	1 wk
Due to: cerebral hemorrhage	1 yrs
Due to: arteriosclerotic cardio-vascular disease	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo A Krupp M. D.
Address 3330 Edmondson Ave Date signed 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658084

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 658084

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gustave Waliunas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1887

8. AGE: Years	Months	Days	If less than one day
60	2 3		hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Tomas Waliunas
13. Birthplace

MOTHER
14. Maiden Name Julia —
15. Birthplace

16 (a) Informant Ella Lindsay Home Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-37 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kazmukas Jr
(b) Address 1604 Washington Blvd

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

DEC 18 1937
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 or 17 1937, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1937 to Dec 16 1937, and that I last saw him alive on Dec 16 1937.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions Arteriosclerosis	4 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature E Gill Hall
Address 1631 E North Ave Date signed 12/17/37 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

058035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 058035

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S. Rae St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Skruck Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1916

8. AGE: Years	Months	Days	If less than one day
31	5	30	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Paul Skruck Sr.
13. Birthplace Poland

MOTHER
14. Maiden Name Margaret Pecar
15. Birthplace Poland

16 (a) Informant Paul Skruck Sr.
(b) Address 516 S. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-47 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 DEC 18 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16 1947 at 1 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1947 to 12-16 1947 and that I last saw him alive on 12-16 1947

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Secondary hepatic insufficiency
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. May M.D.

Address 1400 N. Caroline St. Date signed 12/15/47.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93c

Registered No. 658086

1. PLACE OF DEATH: D. of A
(a) Baltimore City, Maryland
(b) Street address 609 S. Durham St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 S. Durham St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen M. Teraskiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-7308

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband Walter Teraskiewicz

6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Feb, 19, 1921

8. AGE: Years	Months	Days	If less than one day
26	9	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Mach
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Szafasz
15. Birthplace Poland

16 (a) Informant Mrs. Anna Mach (Mother)
(b) Address 609 South Durham Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-47 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) DEC 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1947, at 1 45 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Rheumatic R.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gutierrez M.D.
Medical Examiner.
Date signed 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947 B

Registered No. G58087

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street.
(c) Hospital or institution: 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Sarahanne St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Portia McLean

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick D.
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 7/23/1912

8. AGE: Years	Months	Days	If less than one day
35	4	24	hr. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Charles H. Tilghman
13. Birthplace: Md

MOTHER
14. Maiden Name: Mazie Williams
15. Birthplace: Va

16 (a) Informant: Frederick D. McLean (Hus.)
(b) Address: 1102 Sarahann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore, Nat'l.
Location: Baltimore, Md.

18 (a) Funeral director: Charles G. Cooper
(b) Address: 510-12 N. Carrollton Ave

19 (a) DEC 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17, 1947, at 12.15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Rheumatic heart disease
Due to: Obesity

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/17/47

058038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

Registered No. 058038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Sinai Hosp.
(b) Street address Rutland & Monument
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Hrs
(e) Length of stay in Baltimore (yrs., mos., or days) about 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3813 Towanda Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Israel Darwin

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-9485

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business

FATHER
12. Name not Known
13. Birthplace Russia

MOTHER
14. Maiden Name not Known
15. Birthplace Russia

16 (a) Informant Rose Darwin
(b) Address 3813 Towanda Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-47 (month) (day) (year)
(c) Cemetery or crematory Adas Israel
Location Old Court & German Hill Rds

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eastern Place

19 DEC 18 1947 (Date received by registrar) Waiting for Williams, MD

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1947, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1947 to Dec 17 1947, and that I last saw him alive on Dec 17 1947.

Immediate cause of death	Duration
Left cerebral Hemorrhage	12 hrs.
Due to Hypertension	6 yrs.
Due to Arteriolar nephrosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Rohrberg M.D. M. D.

Address Sinai Hosp Date signed 12/17/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 658089

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Boarman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4008 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Wade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Tillie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17 1876

8. AGE: Years 71 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Tillie Wade
(b) Address 4008 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-47 (month) (day) (year)
(c) Cemetery or crematory Pimlico
Location Pimlico Rd + Hamilton Ave

18 (a) Funeral director Jack Sears Inc
(b) Address 2409 Eutaw Place

19 (a) DEC 18 1947 (b)
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18-1947 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/47 1946 to 12/18/47 1947, and that I last saw h/m alive on 12/18/47 1947.

Immediate cause of death: Acute Cardiac Dilatation — Duration: 1 day

Due to: Hypertensive Cardiac Renal Vascular Disease — Duration: 10 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R A Gunting M. D.
Address 2324 Eutaw Pl Date signed 12/18/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 1a

Registered No. 058090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 N. PATTERSON PK. AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N. PATTERSON PK AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILIP FELDMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	~~MARRIED~~ SINGLE

6 (b) Name of husband or wife ~~Celia~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

FATHER
12. Name HYMAN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant CELIA FELDMAN - MOTHER
(b) Address 3813 RIDGEWOOD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-18-47 (month) (day) (year)
(c) Cemetery or crematory MT CARMEL
Location OLD GERMAN HILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PL.

19 (a) DEC 18 1947 (Date rec'd by registrar) (b) ~~Registrar~~ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18-47 19 ..., at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1947, to Dec. 18 1947; and that I last saw h/~~m~~ alive on 12-17- 1947.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to myocarditis & hypertension	?
Due to	
Other Conditions Chronic Nephritis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph S. Bluem M.D.
Address 1206 E Preston St Date signed 12/18/47

V S 150

93D

1947 12 17
1870 12 2
77 0 15

~~BALTIMORE CITY HEALTH DEPT.~~
~~MARYLAND STATE DEPARTMENT OF HEALTH~~
~~2411 N. Charles Ste, Baltimore~~

1947 B7 65891

CERTIFICATE OF DEATH ✓ 83a

Reg. Dist. No. .....

1. PLACE OF DEATH:

County .....
City or town Baltimore, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs.
Hospital, institution, or street address where death occurred: 14 So. Rosedale St. 20
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County ✓
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. #14 So. Rosedale St.
(If rural, give LOCATION)
2.(a) If veteran, name war No.

3. (a) FULL NAME Ida Virginia Shipley

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	married

6.(b) Name of husband or wife Robert Lee Shipley
6.(c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) Dec. 2 - 1870

8. AGE: Years	Months	Days	If less than one day
77	0	15	..... hrs. ..... min.

9. Birthplace Aa. Co. Md. (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business @ home

FATHER
12. Name Richard Bell
13. Birthplace A.A. Co. Md

MOTHER
14. Maiden name Sally Ann Jeffries
15. Birthplace A. A. Co. Md.

16. Informant Mrs. Arthur M. McClelland
Address 14 So. Rosedale St Balto 29 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/20/47 (month) (day) (year)
Cemetery or crematory FRIENDSHIP CEMETERY
Location ANN A. County, MD.

18. Funeral director WM. J. TICHNER & SONS INC.
Address North & Penna Aves. Balto. MD.

19. DEC 18 1947 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1947 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1936, to Dec. 17 1947
and that I last saw h[illegible] alive on Dec. 17 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	7-20-47
Due to Arteriosclerosis & Hypertension	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Chas. K. Lacy Jr. M. D. or other
Address Linthicum Md. Date signed 12-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 197

Registered No. 058092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland W.
(b) Street address 2015 North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA CATHERINE BOLGIANO

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	M	WIDOW

6 (b) Name of husband or wife Wm. R. BOLGIANO
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/11/? 1854

8. AGE: Years	Months	Days	If less than one day
about 88	8	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Goldie Slater
(b) Address 2015 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEM
Location Balto. MD

18 (a) Funeral director WM. F. TICKNER & SONS INC
(b) Address Nth & Pa. Aves. Balto, MD

19 (a) DEC 18 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16/47 19 , at 5P M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1947 to Dec 16 1947, and that I last saw h alive on Dec 16 1947.

Immediate cause of death	Duration
Myocardial failure	1 year
Due to Arteriosclerosis	3 or more years
Due to 12/6-47 ✓	
Other Conditions Dec 6-47. fall & injured spinal column	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide see other side
(b) Date of occurrence see other side at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature I. Frederick Lantz
Address Temple Garden apts Date signed 12/17/47 M. D.

VS 150

X

58093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 58093

Every item of information should be carefully supplied. The... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3410 Harmony Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 Harmony Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAXMILLIAN J. BEHRINGER

3 (b) If veteran, name war ------
3 (c) Social Security Account No. 210-12-2716

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Helen Behringer
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 18 1887

8. AGE: Years 60 | Months 6 | Days 28 6 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Steel Fabricator.
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Andrew Behringer
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Zippel
15. Birthplace Germany

16 (a) Informant Helen Behringer (Wife)
(b) Address 3410 Harmony Court

17 (a) Burial (b) Date thereof 12-20-47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cemetery
Location 7401 German Hill Rd.

18 (a) Funeral director Charles S. Geiler.
(b) Address 201 S. Conkling St.

19 (a) (Date received by registrar) (b) Thornton for Williams M.D. Registrar

DEC 18 1947

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1947, at 6:00P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 15 1945 to Dec 16 1947.
and that I last saw h[illegible] alive on Dec 16 1947.

Immediate cause of death		Duration
	Cerebral Hemorrhage	Instantaneous
Due to	Chronic Nephritis	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wright J. Dudley
Address 3323 E. Balto St. Date signed 12/16/47 M.D.

658094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1212

658094 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 W. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 W. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Louise Marie Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8, 1890

8. AGE: Years 57 | Months — | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Frank Tasker

13. Birthplace Frederick Md.

MOTHER 14. Maiden Name Rebecca Snively

15. Birthplace Frederick Co Md.

16 (a) Informant Anna Freeman

(b) Address 528 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19, 1947 (month) (day) (year)

(c) Cemetery or crematory W.T. Carlin's Sons

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (Date rec'd by Registrar) Huntington Williams

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/1947 at 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14/1947 to 12/15/1947 and that I last saw h[illegible] alive on 12/15/1947

Immediate cause of death: Cyanosis Bronchopneumonia — Duration

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible]

Address 601 N. Carrollton Ave Date signed 12/16/47 M.D.

G58095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

G58095 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 W Carey St.
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2721 Huntington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie E Parker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife John R Parker.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 1867

8. AGE: Years 80 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John J McDonald

13. Birthplace

MOTHER 14. Maiden Name Sarah E Smuck

15. Birthplace

16 (a) Informant Mrs Gill

(b) Address 2721 Huntington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-47 (month) (day) (year)

(c) Cemetery or crematory St Marys Hampden

Location Balto Md

18 (a) Funeral director Frank H Lantz

(b) Address 814 N 36 St.

19 (a) (b) Registrar

18 [illegible] rec'd by registrar Huntington for Williamsburg

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1947, to Dec 15 1947 and that I last saw her alive on Dec 15 1947.

Immediate cause of death: Acute Cardiac Dilatation — Duration: 3 days

Due to: Hypertension Cardiovascular disease — Duration: ?

Due to:

Other Conditions: Fractured Femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 10/1/47 (?) at M

(c) Where did injury occur? 2721 Huntington Ave (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?

(e) Means of injury Slipped & fell to floor

23. Signature Harry Glassman M. D.

Address 253 W Lafayette St Date signed Dec 19 47

For Dr J R Davis by Herbert J Wiesen M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58096 — BALTIMORE CITY HEALTH DEPARTMENT — G58096 Registered No.

CERTIFICATE OF DEATH 1318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2104 N. Howard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 -
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Missie Darden Wells

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F

5. Color or race colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Thomas Wells

6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1926

8. AGE: Years 21 | Months 10 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Raleigh, N.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Leroy Darden
13. Birthplace Rocky Mount, N.C.

MOTHER
14. Maiden Name Vela Owens
15. Birthplace Mount Olive, N.C.

16 (a) Informant Mrs Vera Darden
(b) Address 2104 N. Howard st. city

17 (a) Burial (b) Date thereof 12/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Md.

18 (a) Funeral director William L. Chatman Jr
(b) Address 1701 McCulloh St. city

19 (a) ____ (b) ____
(Date rec'd by Registrar)
Dec 18 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947 to Dec. 15 1947 and that I last saw h[er] alive on Dec. 14 1947.

	Duration
Immediate cause of death: Uremia Nephritis	
Due to Osteomyelitis	10 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vera A. Johnson
Address 2329 Guilford Ave Date signed Dec 16 1947 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. C58097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Abell ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Abell ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Jerome Gugerty, Jr.

3 (b) If veteran, name war: nO

3 (c) Social Security Account No. 218-03-6935

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Tighe Gugerty

6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Apr. 6, 1895

8. AGE: Years 52 | Months 8 | Days 11 | If less than one day: hr. min.

9. Birthplace: Harford Co. Md. (Town, county, and state)

10. Usual Occupation: Deputy Sheriff

11. Industry or business: City of Baltimore

FATHER
12. Name: Peter J. Gugerty
13. Birthplace: Harford Co.

MOTHER
14. Maiden Name: Alice M. O'Rourke
15. Birthplace: Ireland

16 (a) Informant: Mrs. Anna Tighe Gugerty
(b) Address: 3014 Abell avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location:

18 (a) Funeral director: Chas J Evans & Son Inc
(b) Address: 4 E. W. Mt. Royal Ave

19 DEC 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Dec. 1947, at 3:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Asphyxiation

Due to: Strangulation from Hanging

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/17/47 at 3:40 P.M.
(b) Where did injury occur? 3014 Abell Ave Balto Md
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self-inflicted - hanging

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.
Date signed 17 Dec. 1947

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G58098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2126 E. Federal Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 E. Federal Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISABELLA JANE FARLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.	
No	None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife James Frank Farley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5-1867

8. AGE: Years	Months	Days	If less than one day
80	8	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Braid
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth Slidders
15. Birthplace Scotland

16 (a) Informant: Mr. James W. Farley
(b) Address 2123 E. Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory LORRAINE CEMETERY
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1947, 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1947 to Dec 15 1947, and that I last saw her alive on Dec 14 1947.

	Duration
Immediate cause of death Bronchopneumonia	1 week
Due to Arterio sclerotic Cardio vascular disease	7 years
Due to	
Other Conditions Old Age	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Anthony J. Lohman M. D.
Address 4600 York Rd Date signed 12/16/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 658099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 552 O'Donnell St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 552 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA MARGARETHA KAPPEL

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: WIDOW
6 (b) Name of husband or wife: Philip Kappel
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) June 29, 1872
8. AGE: Years 75 | Months 5 | Days 18 | If less than one day ... hr. ... min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Stange
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15 Birthplace Germany

16 (a) Informant Mrs. Wm Kappel
(b) Address 552 O'Donnel St-24
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-47 (month) (day) (year)
(c) Cemetery or crematory Trinity Lutheran
Location Baltimore Md.
18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY
19 DEC 18 1947 (Date rec'd by registrar) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1947, at 1 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 1946, to Dec. 17 1947, and that I last saw h[illegible] alive on Dec. 15 1947.

Immediate cause of death	Duration
Carcinoma of Side of Neck and Breast	6-8 yrs.
Due to	
Due to	
Other Conditions Mitral Insufficiency	10 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry A. Kelly M. D.
Address 2504 Ashland Ave Date signed 12/17/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1475 Woodall St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1475 Woodall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Adelmann

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Kunigunda Adelmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1858

8. AGE: Years 89 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Butcher

FATHER
12. Name Adelmann
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Richter
15. Birthplace Germany

16 (a) Informant Elizabeth Adelmann
(b) Address 1475 Woodall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Wm. & Wm. John W. Teufel & Son
(b) Address 5311 Edmondson Ave.

19 DEC 18 1947 (Date rec'd by registrar) (b) Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17th 1947, at 6 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1947, to Dec 17 1947 and that I last saw he alive on Dec 17 1947.

Immediate cause of death	Duration
Coronary Sclerosis & Thrombosis	?
Due to Cerebral edema.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 56 E Fort Ave Date signed 12/18/47 (M.D.)

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G58101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Greenway Apts.
(b) Street address — 3401 Greenway
(c) Hospital or institution: 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Greenway (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country ------

3 (a) FULL NAME George H Starks

3 (b) If veteran, name war — no
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Meta Holmes Starks
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov 25, 1867

8. AGE: Years 80 | Months 0 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace New Orleans La (Town, county, and state)

10. Usual Occupation Sec. Treas. Calvert Bldg & Const. Co

11. Industry or business Construction

FATHER
12. Name Charles Starks
13. Birthplace ?

MOTHER
14. Maiden Name Duren Wyld
15. Birthplace ?

16 (a) Informant Harry H. Starks
(b) Address 520 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director H. W. Meeks and Son
(b) Address 805 N. Calvert St.

19 (a) DEC 18 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1947; at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5/ 1947, to Dec 17 1947, and that I last saw h[illegible] alive on Dec 16 1947.

	Duration
Immediate cause of death: Cerebral Vascular accident	1 day
Due to: arteriosclerosis	?
Due to:	
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ____ M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature: Francis M. Gluck M. D.
Address 3406 St Paul St Date signed 12/24/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 658102

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2614 Robb St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Robb St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore W. Hendricks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Julia Daley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 SAT | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Florida (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name Wm. L. Hendricks
13. Birthplace Florida

MOTHER
14. Maiden Name Anna Hanford
15. Birthplace Florida

16 (a) Informant Mrs. Julia D. Hendricks
(b) Address 2614 Robb Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Megginson
(b) Address 805 N. Calvert St

19 (a) DEC 18 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1947, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Feldmeier M.D.
Medical Examiner.
Date signed 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

G58103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

162 B

G58103 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Mt. St. Agnes, Md. Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Helena, Laurence R.S.M.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1850

8. AGE: Years	Months	Days	If less than one day
97	5	0	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Michael Lawrence
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary M. Hilt
15. Birthplace Penna.

16 (a) Informant Mother Provincial
(b) Address 3707 Smith Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt. St. Agnes Convent Cemetery
Location Mt. Washington, Md.

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St

19 (a) DEC 18 1947 (Date rec'd by registrar) (b) Huntington for Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1947, at 8:12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1947, to Dec. 17 1947, and that I last saw her alive on Dec. 16 1947.

Immediate cause of death: Dehydration, cachexia — Duration

Due to: Hypostatic pneumonia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature Robert F. Johnson M. D.
Address Mercy Hospital Date signed 12/17/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

Registered No. 65104

65107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address I737 Light Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. I737 Light Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Peters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Catherine Howser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) II/27/I866

8. AGE: Years	Months	Days	If less than one day
8I	—	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Street Cleaner
11. Industry or business City Of Balto.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Family
(b) Address I737 Light Street

17 (a) B (Burial, cremation, or removal) (b) Date thereof I2/20/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director Edward L. McCauley
(b) Address I30 E. Fort Ave.

19 Dec 18 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1947 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Dec 17 1947 and that I last saw h alive on Dec 17 1947

Immediate cause of death	Duration
— Carcinoma of Respiratory Organs	11 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. B. Wells M.D.
Address I779 William St Date signed 12/15/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 80 B

Registered No. G58105

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 EDGEWOOD RD.
(c) Hospital or institution: 15
ABOVE ADDRESS
(d) Length of stay in ~~hospital or inst.~~ (yrs., mos., or days) 8 YRS
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County ~
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 EDGEWOOD RD
(If rural give location)
(e) Citizen of foreign country? ~ (Yes or No)
If yes, name country

3 (a) **FULL NAME** MALCOLM ANTON DIGGES

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: HELEN L.
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) MAR. 18, 1879

8. AGE: Years 68 | Months 8 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Charles Co. Md.
(Town, county, and state)

10. Usual Occupation Retired (accountant)

11. Industry or business B & O. R.R.

FATHER
12. Name Claude Digges
13. Birthplace Charles Co. Md.

MOTHER
14. Maiden Name Emily R. Brent
15. Birthplace Charles Co. Md

16 (a) Informant Mrs. Helen L. Digges
(b) Address 3602 Edgewood Rd. Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Pylesville Md.

18 (a) Funeral director Wm. H. Keller & Sons Inc.
(b) Address North & Pa. Aves. Balto. Md.

19 (a) Date received by Registrar DEC 18 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16/47 19__, 12:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1935, to 12/16 1947, and that I last saw h. alive on 12/15, 1947.

	Duration
Immediate cause of death Bronchio-pneumonia	3 days
Due to Cyanosis	
Due to Urinary incontinence	1 yr.
Other Conditions Chronic Encephalitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. H. Hayward M.D.
Address 115 E Eager St Date signed 12/18/47

1339

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 658106

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 Homestead St.
(c) Hospital or institution: home 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) Born in Baltimore - Returned
(e) Length of stay in Baltimore (yrs., mos., or days) 1926

2. USUAL RESIDENCE OF DECEASED:
(a) State Baltimore (b) County Md
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Homestead St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Leah Benfer

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Henry A. Benfer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1865

8. AGE:	Years	Months	Days	If less than one day
82		5	13	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business —

FATHER
12. Name Benjamin Hengst
13. Birthplace York County, Pa.

MOTHER
14. Maiden Name Mary Dunkel
15. Birthplace Lewisburg, Pa.

16 (a) Informant Dr. Kenneth L. Benfer
(b) Address York, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec-19-47 (month) (day) (year)
(c) Cemetery or crematory Monsville
Location Manysville Pa.

18 (a) Funeral director L. Stewart Morris Co.
(b) Address 108 W North Ave

19 DEC 18 1947 (Date rec'd by registrar) Funeral for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1947 at 1:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1944 to Dec. 17 1947 and that I last saw her alive on Dec. 16 1947

Immediate cause of death	Duration
Myocarditis	1 yr.
Due to Chronic Nephritis	5 yrs.
Due to Arterio-sclerosis	
Other Conditions Advanced Age.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Barton I. Baggott M. D.
Address 3812 Greenmount Ave Date signed Dec 17 47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 36

Registered No. G58107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address HARFORD ROAD &
(c) Hospital or institution: HERRING RUN SYDENHAM HOSPITAL 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) /
(e) Length of stay in Baltimore (yrs., mos., or days) 9 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore, 15, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2608 Manhattan Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELISE R. ANDERSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25, 1938

8. AGE: Years	Months	Days	If less than one day
9	1	21	hr. min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)

10. Usual Occupation STUDENT

11. Industry or business SCHOOL

FATHER
12. Name PAUL N. ANDERSON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name HELEN WINEL
15. Birthplace MARYLAND

16 (a) Informant PAUL N. ANDERSON
(b) Address 2601 Manhattan Ave, Bal

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Fanning Bayless
(b) Address 5905 Park Heights Ave

19 (a) DEC 18 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 16 1947, at 2:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 16 1947 to DEC 16 1947 and that I last saw her alive on DEC. 16 1947

Immediate cause of death	Duration
Respiratory failure	
Circulatory collapse	
Due to Poliomyelitis Bulbar	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Tracheotomy
Major findings of operation: Dec. 16, 1947
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold A. Cooper M. D.
Address Sydenham Hosp. Date signed Dec 16, 1947

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered No. 58108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 N. Decker Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 N. Decker Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Edwin Harris, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Bertha M (nee Peters) Mahla-Harris 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1876

8. AGE: Years	Months	Days	If less than one day
71	1	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Harry R. Harris
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace W

16 (a) Informant Mrs. Bertha M. Harris
(b) Address 526 N. Decker Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) DEC 18 1947 (Registrar's signature) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16/47, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/1946, to 12/16/1947 and that I last saw h[illegible] alive on 12/14/1947.

Immediate cause of death	Duration
Hypertension Cardio Vascular Renal Disease	7
Due to	
Due to	
Other Conditions Coronary Thrombosis	4 hrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ellis L. Silberstein, M.D.
Address 2939 W. Ellerslie Date signed 12/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

058109 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 N. Rose St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 N. Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Kubin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/1/1878

8. AGE: Years	Months	Days	If less than one day
69	9	16	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Zunt
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Emelie Sychuk - daughter
(b) Address 803 N. Rose Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/1947 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

DEC 18 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to Dec 17 1947, and that I last saw [illegible] alive on Dec 17 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 5 days

Due to Hypertension

Due to Arterio-sclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Davenport M. D.
Address 3400 E. Madison Date signed 12/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

658110

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

658110
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4701 Norwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 d
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Norwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jean Ramage Peake

3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Archibald Peake
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.): Oct. 19. 1883

8. AGE: Years 64 | Months 2 | Days 27 | If less than one day: hr. min.

9. Birthplace: Brownsville Pa.
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: John Ramage
13. Birthplace: Pa

MOTHER
14. Maiden Name: Amber Linley
15. Birthplace: Pa

16 (a) Informant: Archibald Peake
(b) Address: 4701 Norwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 19 1947 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem
Location: Baltimore Md.

18 (a) Funeral director: Miller Funeral
(b) Address: 4510 Liberty Heights Ave.

19 Date filed by Registrar: DEC 18 1947 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 16 1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1947 to Dec. 16 1947, and that I last saw h[illegible] alive on Dec. 16 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	1hr
Due to: Hypertension / Arteriosclerosis	1 yr. +
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Leo Schlenger M.D.
Address: 4500 Liberty Hghts Ave Date signed: 12/18/47

Death certificate signed under authorization of Medical Examiner

VS 188

658:11

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 658:11

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every question must be answered, or the information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2410 Francis St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 N. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1870

8. AGE: Years 77 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Elkridge, Md. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

FATHER 13. Birthplace

MOTHER 14. Maiden Name Lovinia Barnes

MOTHER 15. Birthplace Maryland

16 (a) Informant Mrs. Ida Barnes

(b) Address 1217 N. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20, 1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director Jas. George H. Hallenbeck

(b) Address 1605 Druid Hill Ave.

19 (a) DEC 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Dec. 1947 at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Arteriosclerotic Cardio-Vascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.

Date signed 17 Dec. 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green st
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Fork Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Cornthwaite

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16. 1855

8. AGE: Years 92 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Fork Md (town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Self

FATHER
12. Name W. H. Cornthwaite
13. Birthplace Md

MOTHER
14. Maiden Name Jane Reed
15. Birthplace Md

16 (a) Informant

(b) Address -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Fork M. E. Cem

Location Fork Md.

18 (a) Funeral director A. C. Arthur

(b) Address Fork Md

DEC 18 1947 (Date rec'd by registrar) (b) Registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1947, at 12:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14 1947 to 12/16 1947, and that I last saw him alive on 12/15 1947.

	Duration
Immediate cause of death: Cerebral embolism	
Due to: Lobar pneumonia	
Due to: Congestive Heart Failure	
Due to: Generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Univ. Hosp. Date signed 12/16/47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43a

G58113 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 258 S. Caton Ave.
(c) Hospital or institution: 26-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 258 S. Caton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Promutico

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 212-01-8422

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Rose Promutico

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 1893

8. AGE: Years 54. Months 4. Days 13 If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name John Peatist
13. Birthplace Italy

MOTHER 14. Maiden Name Carmel Catalano
15. Birthplace Italy.

16 (a) Informant Anthony Promutico
(b) Address 258 S. Caton St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 12-19-47 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Edmondson Ave

18 (a) Funeral director Wendel & Dippel
(b) Address 812 6 High Ward Lane

19 (a) (Date received by Registrar) (b) Registrar Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1947 at 10 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to December 15 1947 and that I last saw him alive on Dec. 15 1947.

Immediate cause of death	Duration
Hemorrhage in Brain	0
Due to General Arterio Sclerosis	about 6 Months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 716 Date signed 12-19-47

V3 153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C38114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1c

C58147 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hosp. 8-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [illegible]
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 N. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Christian Seifert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Male | 5. Color or race White | 6 (a) Single, ~~married, widowed or divorced~~ Single

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/22/1867

8. AGE: Years 80 | Months 3 | Days 26 | If less than one day hrs. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Christian Seifert.
13. Birthplace Germany

MOTHER 14. Maiden Name Henrietta Seifert
15. Birthplace Germany

16 (a) Informant Mrs. Ella Valentine
(b) Address 902 E Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/47 19..., at 10 M

21. I certify that death occurred on the date above stated, that I attended deceased from 12/6/47 to 12/18/47, and that I last saw h[illegible] alive on 12/15/47.

Immediate cause of death	Duration
1. Coronary thrombosis, left	
Due to 2. Arteriosclerosis	
Due to 3. coronary disease, marked	
Other Conditions 4. Unattended fracture, marked	

(Include pregnancy within 3 months of death)

Date of operation None.
Major findings of operation:
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph D'Antoni M. D.
Address Church Home & Hosp. Date signed 12/18/47

VS 150

658115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 658115

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp. 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph A Vasalock

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs Caroline Vasalock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-15-08

8. AGE: Years	Months	Days	If less than one day
39	0	3	hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation Conveyor belt operator
11. Industry or business Fruit Industry

FATHER
12. Name ? Vasalock
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace 1314 W. Balto. St.

16 (a) Informant Mrs Caroline M. Vasalock
(b) Address 1314 W. Balto. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/47 (month) (day) (year)
(c) Cemetery or crematory Mens Cathedral
Location Balto - Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 19 1947 (Date rec'd by registrar) (b) Funeral director for Williams M[illegible]

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18 1947, at 7:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8 1947 to 12-18 1947 and that I last saw h[illegible] alive on 12-18 1947

Immediate cause of death Sudden Circulatory Collapse — Duration

Due to probable cardiac infarction

Due to —

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: Coroners autopsy - Not yet received

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Fuller M. D.
Address Bon Secours Hosp. Date signed 12-18

058:16

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

058:16 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Ridgely St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kershner R. George
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Divorced
6 (b) Name of husband or wife Rose Smith
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 4th 1885
8. AGE: Years 62 Months 4 Days 14 If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Paper Hanger
11. Industry or business Wrisp-Scriber
FATHER 12. Name Louis E. Kershner
13. Birthplace Balto. Md.
MOTHER 14. Maiden Name Elizabeth Horn
15. Birthplace Balto. Md.
16 (a) Informant Bertha Kershner
(b) Address 721 W. Cross St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Md.
Location "
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
19 (a) DEC 19 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1947, at 1:45 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1947 to 12/18 1947, and that I last saw him alive on 12/10 1947

Immediate cause of death	Duration
Cerebral Angina	
Due to Bronchogenic carcinoma with multiple thoracic	
Due to and abdominal extension + metastases.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature David D. Philly M. D.
Address Univ. Hosp. Date signed 12/19/47

G58117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G58117 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Home Jno. Gill Hale MD
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 557 E. 38th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Neary

3 (b) If veteran, name war 1
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. S.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 17, 1886
8. AGE: Years 61 | Months 6 | Days | If less than one day ____ hr. ____ min.
9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Patrick Neary
13. Birthplace

MOTHER
14. Maiden Name Ann McCarthy
15. Birthplace

16 (a) Informant Estelle Linton Fee Poe
(b) Address 1207 Valley St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Fredricks Rd
18 (a) Funeral director John A. Moran
(b) Address 3000 E. Baltimore St.
19 DEC 19 1947 (Entered by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1947, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 - 1947 to Dec 17 - 1947 and that I last saw her alive on Dec 16 - 1947

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions Arteriosclerosis	4 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. Gill Hale M.D.
Address 1631 E North Av Date signed 12/18/47 M. D.

658118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 658118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 GARRETT AVE (If rural give location)
(e) Citizen of foreign country? n. NO (Yes or No) If yes, name country

3 (a) FULL NAME RUTH E. ? MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	MARRIED

6 (b) Name of husband or wife EVERETT MILLER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 6, 1922

8. AGE: Years	Months	Days	If less than one day
25	7	12	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name JOHN DRESSEL
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ANNIE APPLER
15. Birthplace BALTIMORE, MD.

16 (a) Informant ADMISSION NOTE Everett E. Miller Jr.
(b) Address 2541 Garrett ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 23 47 (month) (day) (year)
(c) Cemetery or crematory Maryland Mem. Park
Location Taylor ave

18 (a) Funeral director Howard A. Blight Jr.
(b) Address 6009 Harford Road.

19 DEC 19 1947 (Date rec'd by registrar) Signature for Williams Mitchell (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 18 1947 at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 12 1947 to DEC 18 1947 and that I last saw h.e.r alive on 12/18 1947

Immediate cause of death: CARDIAC FAILURE — Duration

Due to RHEUMATIC HEART DISEASE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elden Hulett Peaty M. D.
Address Mercy Hosp. Date signed 12/18/47

VS 150

X

658119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

658119 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 743 W Baltimore and 42
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 743 W Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Columbia Carroll Carroll
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. widow
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 1st 1859
8. AGE: Years 88 | Months 6 | Days 17 | If less than one day hr. min.
9. Birthplace Carroll W. Va. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Benjamin F. Vannueter
13. Birthplace Virginia

MOTHER
14. Maiden Name Catherine Musteo
15. Birthplace West Virginia

16 (a) Informant Troy Carroll
(b) Address 743 W Balto St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/47 (month) (day) (year)
(c) Cemetery or crematory Shiloh W. Va.
Location Shiloh Church W. Va.
18 (a) Funeral director Chas Powell.
(b) Address 2427 Edmondson Ave
19 DEC 19 1947 (Date rec'd by Registrar) Huntington Williams M.E. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1947, at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947, to Dec 17 1947, and that I last saw h.e. alive on Dec 17 1947.

Immediate cause of death Pneumonia - Bilateral - | Duration 2 weeks
Due to
Due to
Other Conditions Arteriosclerosis C.V.D | 5 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Selby
Address 1301 Arunah Date signed 12/18/47

107

658120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 658120

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County Baltimore
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1298 Riverside Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Lauenroth, Jessie Jessie C. Lauenroth
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife August Lauenroth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1912

8. AGE: Years	Months	Days	If less than one day
35	4	17	hr. min.

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER 12. Name Harry Fadd
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Maude Powell
15. Birthplace Maryland

16 (a) Informant August Lauenroth - Husband
(b) Address 1298 Riversideave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Richmond Highway, P. O. Fabius Station

18 (a) Funeral director S. S. Light & Sons
(b) Address 21 S. Light St.

19 DEC 19 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/47 19 , at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 19 47 to 12/17 19 47, and that I last saw h. alive on 12/17 19 47

Immediate cause of death	Duration
Terminal Bronchopneumonia	
Due to Diabetic Coma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Bronchopneumonia Atrophy of Pancreas

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Ralph Kleaveland M. D.
Address 1 Elm Terrace Date signed 12/19/47

658121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. 658121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT St. & RUTLAND Av.
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 337 Nicholson Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ~~LENA WEINRICH~~ Lena Weinreich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife JOHN WEINRICH
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan. 25th, 1888

8. AGE: Years	Months	Days	If less than one day
59	10	23	..... hr. ..... min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name Jos. Zeller
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. John R. Weinreich
(b) Address 337 Nicholson Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Lasarah Funeral Home
(b) Address 7401 Belair Road

DEC 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 18, 1947, at 11:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1947 to Dec 18 1947 and that I last saw her alive on Dec 18 1947

Immediate cause of death Cardiac failure

Due to Bronchopneumonia Carcinoma with metastases to adrenals, brain

Due to Kidneys.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irvin M. Gushner M. D.
Address Sinai Hospital Date signed Dec 18, 1947

T 58122 LW 115915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. C58122

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 W. York (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Farley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
49 ?			hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B.C.H.Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James Stoops
(b) Address 142 Wolfe St

19 DEC 19 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16- 1947, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15- 1947 to 12-16 1947 and that I last saw h im alive on 12-16 1947.

Immediate cause of death	Duration
Tuberculosis of lungs, far advanced	2yr
Due to	
Due to	
Other Conditions Congestive Heart Failure, Cardiac Hypertrophy	3yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight W. Parks M. D.
Address Balt City Hosp Date signed 12-19-47

658123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

658123
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident 1124
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 McCulloh Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CORA HARMON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-29-86

8. AGE: Years 61 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Northampton, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Harrison
13. Birthplace Va

MOTHER
14. Maiden Name Anne Christian
15. Birthplace Va

16 (a) Informant Benjamin Harmon
(b) Address 1238 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)

(c) Cemetery or crematory
Location Forley, Va.

18 (a) Funeral director Charles R Law
(b) Address 502 mad ave.

19 (a) DEC 19 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/47 19 at 5:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Peers M.D. Medical Examiner.
Date signed 12/18/47

X

58121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓131a

Registered No. 58124

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 E. Preston Street
(c) Hospital or institution: 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 E. Preston St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1895

8. AGE:	Years	Months	Days	If less than one day
	52	6	5	hr. min.

9. Birthplace Chaway Co., Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Fitzgerald
13. Birthplace Va.

MOTHER
14. Maiden Name Agnes Fitzgerald
15 Birthplace Va

16 (a) Informant Mrs Corine Bland
(b) Address 1620 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)
(c) Cemetery or crematory B
Location Blacketone, Va.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 DEC 19 1947 (Date received by local registrar) (b) Funeral Director for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16 1947 to 12-18 1947 and that I last saw ~~him~~ her alive on 12-18-47 19

Immediate cause of death: Acute Myocarditis — Duration 1 D

Due to: Cardio-Renal Vascular Disease — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Lemmon

Address 1420 E. Chase Date signed 12-19-47 M

X

G58125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G58125

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-1
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 739 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis KLEINMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years 92 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Lith

MOTHER
14. Maiden Name Not Known
15. Birthplace Lith

16 (a) Informant Max Kleinman
(b) Address 615 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Curtis Inc
(b) Address 2600 Eutaw Place

19 DEC 19 1947 at Curtis for Williams M.E.
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1947, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fracture of pelvis

Fracture of both tibiae and fibulae.

Due to

Other Conditions Arteriosclerosis.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-16-47 at 6:50 A.M. 14/3
(b) Where did injury occur? West North Avenue & Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by bus

23. Signature George L. Merrill M.D.
(Medical Examiner.)

Date signed 12/18/47

658:26

AB-115922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

20B

658:26

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs.?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. Crownsville State Hospital

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Richard Sorrell

3 (b) If veteran, name war

3 (c) Social Security Account No. 200-09-1943

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	?

6 (b) Name of husband or wife Rosie Sorrell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? June, 1912

8. AGE: Years	Months	Days	If less than one day
35?	6		hr. min.

9. Birthplace ? Richmond Co., Virginia (Town, county, and state)

10. Usual Occupation Oyster Shucker

11. Industry or business

FATHER

12. Name Walter Thompson.

13. Birthplace Richmond County, Va.

MOTHER

14. Maiden Name Hannah

15. Birthplace Richmond County, Va.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20. 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St

19 DEC 19 1947 (Date rec'd by Registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16- 19 47, at 2.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15- 19 47 to 12-16 19 47

and that I last saw h. 1m alive on 12-16 19 47.

Immediate cause of death B-I Tract Hemorrhage - site undetermined — Duration

Due to Hypertensive C-V Disease

Due to Subacute Glomerulo-nephritis

Other Conditions General Paresis Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: See above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Herbert R. Farber M. D.

Address Balto. City Hosps. Date signed 12-17-47

937

658127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 658127

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16½ N. Pine St.
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16½ N. Pine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Mitchell.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Samuel Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1895

8. AGE: Years 52 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Spartenburg, S.C. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Berry Dunn
13. Birthplace Spartenburg, S.C.

MOTHER
14. Maiden Name
15. Birthplace Spartenburg S.C.

16 (a) Informant Samuel Mitchell
(b) Address 16½ N. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-1947 (month) (day) (year)
(c) Cemetery or crematory Int. Arbutus
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 19 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15 1947, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1947, to 12-15 1947, and that I last saw her alive on 12-14 1947 12 pm

Immediate cause of death	Duration
cerebral hemorrhage	
Due to Hypertensive Cardio-vascular accident	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Jamison M. D.
Address University Hosp. Date signed 12-15-47

VS 150

658128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

658128 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2923 Belmont Avenue
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Belmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK THOMAS WALTMAN, SR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife MARY ANN MEEHAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1 1870

8. AGE: Years	Months	Days	If less than one day
77	0	17	hr. min.

9. Birthplace ADAMS Co PA.
(Town, county, and state)

10. Usual Occupation RETIRED
11. Industry or business GROCERYMAN

FATHER
12. Name NATHANIAL T. WALTMAN
13. Birthplace Pa

MOTHER
14. Maiden Name VIOLET THOMAS
15. Birthplace Pa.

16 (a) Informant MR. FRANKLIN WALTMAN
(b) Address 1608 Walnut St. Phila. Pa.

17 (a) BURIAL (b) Date thereof 12/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ LOUDON PARK CEM
Location BALTO. MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address West & Pa. Ave. Balto. MD.

19 (a) 12 19 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/47 19 , at 8 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 12/19/47

VS 181

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~58129~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 058129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 WEST ROGERS AVE.
(c) Hospital or institution:
HOME for the AGED of the METHODIST CHURCH
(d) Length of stay in hospital or inst. (yrs., mos., or days) Nov 2, 1946
(e) Length of stay in Baltimore (yrs., mos., or days) 75 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. ROGERS AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REV. FRANK REID ISAAC

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	White	WIDOWER

6 (b) Name of husband or wife Naamah CHAMPAGNE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) JUNE 15, 1860

8. AGE: Years	Months	Days	If less than one day
87	6	3	hr. min.

9. Birthplace ELLICOTT City, MARYLAND
(Town, county, and state)
10. Usual Occupation RETIRED PREACHER
11. Industry or business

FATHER
12. Name WM. ANDREW JACKSON ISAAC
13. Birthplace MARYLAND

MOTHER
14. Maiden Name SUSAN OLIVER
15. Birthplace MARYLAND

16 (a) Informant MIRIAM O. COATES - Supt.
(b) Address 2211 W ROGERS AVE. BALTO, MD.

17 (a) BURIALS (b) Date thereof 12/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET CEM.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address NORTH & PENNA AVES. BALTO, MD.

19 DEC 19 1947 Huntington Williams M.D.
(Date rec'd by Registrar) (Registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1947, at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1946 to Dec 17 1947, and that I last saw h[illegible] alive on Dec 17 1947.

	Duration
Immediate cause of death Myocardial degeneration	2 wks.
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J. Jones M. D.
Address 1020 W 33rd St Date signed 12-15-47

658130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

658130
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 336 St Dunstans Rd
(c) Hospital or institution: 27-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 336 St Dunstans Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA R. HADDAWAY

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: REV. GEO. W. HADDAWAY
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) APR. 12, 1867

8. AGE: Years: 80 | Months: 8 | Days: 6 | If less than one day: hr. min.

9. Birthplace: BALTIMORE
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE
11. Industry or business

FATHER
12. Name: LAWSON L. MARTIN
13. Birthplace: HARFORD CO. MD.

MOTHER
14. Maiden Name: JANE R. HENNING
15. Birthplace: RALEIGH, N.C.

16 (a) Informant: MRS. MILDRED HADDAWAY
(b) Address: 336 St. DUNSTANS RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ LOUDON PARK
Location: BALTIMORE, MD.

18 (a) Funeral director: WM. J. TICKNER & SONS INC
(b) Address: NORTH & PENNA. AVES. BALTIMORE, MD.

19 DEC 19 1947 (Date rec'd by registrar) (b) Registrar: Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1947, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1947 to Dec 18 1947, and that I last saw h alive on 12/18 1947

Immediate cause of death	Duration
(a) Chronic myocardial degen.	10 yrs.
Enlarged Prost.	
Due to (b) Acute incontinence	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. L. Jones M.D.
Address: 2818 E. Pratt Date signed: 12/18/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C58131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 426 N Lakewood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 2
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N Lakewood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Collens

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Katherine Collens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1862

8. AGE: Years	Months	Days	If less than one day
85	5	26	hr. min.

9. Birthplace Sweden
(Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business

FATHER
12. Name Robert Collens
13. Birthplace Sweden

MOTHER
14. Maiden Name Dont know
15. Birthplace Sweden

16 (a) Informant Mrs Frederick Tiemeyer
(b) Address 811 Northern Parkway

17 (a) Burial (b) Date thereof Dec 13
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Catonsville

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) DEC 12 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 85

20. DATE OF DEATH Dec 11 - Th 1947, at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1947 to Dec 11 1947 and that I last saw h alive on Dec. 9 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	4 hours
Due to Arteriosclerotic Heart	5 yrs.
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D.
Address 2413 E Monument St

12/18/47

658132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

658132 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1423 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1423 E Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Wash. W. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Lynchburg Va. (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Winston Patrick
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Ernest Jackson
(b) Address 402 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elmer Davidson
(b) Address 1000 Broadway

19 DEC 19 1947 (Date rec'd by registrar) Huntington Nathaniel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/47 19..., at 6:03 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1946, to 12-16 1947 and that I last saw h[er] alive on 12-16 1947.

Immediate cause of death	Duration
Chr. nephritis	
Due to arterio Sclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. G. Nicholson M. D.
Address 2230 Eutaw Pl Date signed 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

VS 150

X

58133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G58133 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave
(c) Hospital or institution: Tendeligh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Clipper Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie M. Pearce

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Thomas L. Pearce
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr) Oct 11, 1877

8. AGE: Years	Months	Days	If less than one day
70	2	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles Napier
13. Birthplace Germany.

MOTHER
14. Maiden Name Mary A. Crem
15. Birthplace Maryland.

16 (a) Informant Thomas L. Pearce
(b) Address 3630 Parkdale Ave

17 (a) Burial (b) Date thereof Dec 20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Mary's
Location Hampden

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 130 A

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1947, at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1947 to Dec 17 1947 and that I last saw h[illegible] alive on Dec 17 1947.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Date signed Dec 19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

658134
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Burk Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3 (a) FULL NAME Henry Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/12/1880

8. AGE: Years 67 Months 6 Days 5 If less than one day hr. min.

9. Birthplace Lexington Ky.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Rev. C. L. Whitfield
(b) Address 218 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location West Port Balto-md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St

19 (a) Received 12-19-1947 (Date rec'd by local registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/1947 at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14 1947, to 12/17 1947, and that I last saw h[illegible] alive on 12/17 1947.

Immediate cause of death	Duration
Hypertensive Cardio Vascular Renal Disease	
Due to Congestive Failure	
Due to Bronchopneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Garner M. D.
Address 1514 Division St Date signed 12/18/47

VS 150

658135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

658135 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2127 St. Paul St
(c) Hospital or institution: 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 St. Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Rosier Sherman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ Louis F. Sherman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1st 1882

8. AGE: Years	Months	Days	If less than one day
65	7	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name (Unknown) Rosier
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Cambridge Md.

16 (a) Informant Louis Sherman
(b) Address 2127 St. Paul St.

17 (a) Entombment (b) Date thereof 12/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) DEC 20 1947 (Date received by registrar) (b) ~~Huntington~~ Williams M.D.

VS 180 A

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18th 1947 at 9a. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1st 1947 to Dec 18 1947 and that I last saw h W alive on Dec 18 1947

Immediate cause of death Carcinoma

Duration
1 mo

Due to Carcinoma Breast 1 yr

Due to Intestinal Obstruction 2 days

Other Conditions Chronic Enteritis 2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 913 Harrison St Date signed Dec 19 47

658136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

658136 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1830 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2830 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles G. Frost

3 (b) If veteran, name war: M
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married
6 (b) Name of ~~husband or~~ wife: Lottie May Frost
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1. 1893
8. AGE: Years 54 | Months 9 | Days 17 | If less than one day hr. min.
9. Birthplace Baltimore Co. Md (Town, county, and state)
10. Usual Occupation Sign Painter
11. Industry or business Morton Sign Co

FATHER
12. Name Frank G. Frost
13. Birthplace Md

MOTHER
14. Maiden Name Rosalie Schaefer
15. Birthplace Md

16 (a) Informant Lottie May FROST
(b) Address 2830 Frederick Ave
17 (a) Burial, cremation, or removal (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery or crematory London Park Md
Location Baltimore
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st
19 (a) DEC 19 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1947, to 19, and that I last saw h~~im~~ alive on Dec 18 1947.

	Duration
Immediate cause of death: Myocarditis	about 6 mo.
Due to: Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Dublett M. D.
Address 2220 Garrison Blvd Date signed

VS 150

Dec 19/47

658137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2757 Almeda Blvd
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2757 Almeda Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dona N. Humphreys

3 (b) If veteran, name war

3 (c) Social Security Account No. 777

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ralph W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3-1901

8. AGE: Years 46 Months 8 Days 20 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Frank Addison

13. Birthplace Balto

MOTHER 14. Maiden Name Isabelle Cunningham

15. Birthplace Balto.

16 (a) Informant Ralph W. Humphreys

(b) Address 2757 Alameda Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem

Location Parkville, Balto Co.

18 (a) Funeral director Wm Cook Inc

(b) Address 1217 St Paul St

19 (a) DEC 19 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/47 at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Strangulating gas

Due to

Other Conditions Dangerously

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12/18/47 about 2:00 P.M.

(b) Where did injury occur? 2757 Almeda Blvd

(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No

(d) Means of injury Gas inhalation from open unlit burners and

23. Signature Owen C. Gilbreath M.D. Medical Examiner.

Date signed 12/19/47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

658138
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 151
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1547 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK STEWART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/1934

8. AGE: Years 13 | Months 9 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Geo. Stewart
13. Birthplace Md

MOTHER 14. Maiden Name Edith Johnson
15. Birthplace Md

16 (a) Informant Edith Stewart
(b) Address 1547 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1383 Pressman St

DEC 19 1947 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1947, at 7 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shotgun wound of right chest and abdomen

Due to Hemorrhage and shock

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-16-47 6.30 a. M.
(b) Where did injury occur? 566 N. Fremont St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

Signature Carl L. Ryder M.D. (Medical Examiner)

Date signed 12-17-47

58139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

58139 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address
(c) Hospital or institution:
Providence Hospital 1162
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N. Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Briscoe

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M.

6 (b) Name of husband or wife Charles Briscoe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/10/1878

8. AGE: Years	Months	Days	If less than one day
49	.	7	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation H. Wife

11. Industry or business

FATHER
12. Name Fred Molden
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace Md.

16 (a) Informant Charles Briscoe
(b) Address 900 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pressman St

19 (a) DEC 19 1947 (Date rec'd by registrar) (b) Arlington Williamsburg Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1947, at 6:34 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/17/47

658140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 658140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dont know
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Market Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward McDonnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years: about 70 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Del
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name John McDonnell

13. Birthplace Ireland

14. Maiden Name Margaret Slavens

15. Birthplace Ireland

16 (a) Informant Mealy Funeral Director

(b) Address Wilmington Del

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22 1947 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Wilmington Del

18 (a) Funeral director John C Mealy

(b) Address 3000 E Baltimore St Baltimore Md

19 (a) DEC 19 1947 (Date rec'd by registrar) (b) Kenneth for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18- 1947 at 1 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

25. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 12/18/47

VS 181

Physicians: please write the causes of death clearly and legibly. ... correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. X 65811 / 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. C. Sterling

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Brought in by
(b) Address Halethorpe Ambulance

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 10, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1947 at 4 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5 1947 to 12-6 1947, and that I last saw him alive on 12-6 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Jamison M. D.
Address University Hosp Balto. Md. Date signed 12-7-47

G58142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G58142 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 N. Charles St
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice H. Dobson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: Benjamin Dobson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15th 1888

8. AGE: Years 59 | Months 0 | Days 3 | If less than one day hr. min.

9. Birthplace: New York
(Town, county and state)

10. Usual Occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: William H. Ropes
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Annie Chapin
15. Birthplace: Unknown

16 (a) Informant: Robert H. Dobson
(b) Address: 928 N. Charles St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/20/47
(month) (day) (year)
(c) Cemetery ~~or crematory~~: Morland Park
Location: Parkville Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St

19 DEC 19 1947 (b)
(Date rec'd by registrar) Huntington-Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18th 1947, at 5:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to Dec 18 1947 and that I last saw h~~er~~ alive on Dec. 8 1947

Immediate cause of death: Heart failure — Duration: minutes

Due to: Endocarditis years ago. Causing mitral insufficiency

Due to: Cardiac hypertrophy - recently symptoms of

Other Conditions: Heart muscle -

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Harry D. McCarty M. D.

Address 37 W. Preston St Date signed 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

658143 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 E. Jefferson St.
(c) Hospital or institution: 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 E. Jefferson St (If rural, give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Alvata Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5 Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Charles A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1894

8. AGE: Years 53 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Pocomoke City Md. (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Stephen Quinn
13. Birthplace Pocomoke City Md

MOTHER
14. Maiden Name Emeline ? ? ?
15. Birthplace Maryland

16 (a) Informant Mr. Chas. Quinn
(b) Address 1504 E. Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George W. Holland
(b) Address 1681 Druid Hill Ave.

19 DEC 19 1947 (b) Date rec'd by registrar Huntington Williams

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1947 at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 1947 to Dec 17th 1947 and that I last saw h.. alive on Dec 17th 1947

Immediate cause of death (a) Decompensated Heart - Insufficiency — Duration: about 6 years

Due to (b) Hypertension

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karl Traugott, M. D.
Address 1623 E. N Ave Date signed 12/18/47

G58144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered G58144

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1146 Shield Place 17-2
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1146 - Shields Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Jane Ball

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years 91 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Lillian Williams
(b) Address 1146 Shield Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 19, 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location Baltimore City

18 (a) Funeral director Leonard F. Whalen
(b) Address 1642 Myrtle ave

19 (a) DEC 19 1947 (When rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 / 15 1947, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1947 to 12/15 1947, and that I last saw h alive on 12/13 1947

Immediate cause of death Terminal Bronchio-pneumonia

Due to Carbo Vascular Renal disease, senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 Mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. F. Jackson M. D.
Address 600 Allendale Rd 12/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 658145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4636 Kernwood Ave
(c) Hospital or institution: 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4636 Kernwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Fannie Whittemore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married,~~ widowed, or divorced. Widowed

6 (b) Name of husband John R. Whittemore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27th 1862

8. AGE: Years 85 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Andrew Perry
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Jane Whitter
15. Birthplace Balto. Md.

16 (a) Informant Mrs Henry Notter
(b) Address 4636 Kernwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St

19 (a) DEC 19 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18th 1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1947, to Dec. 18 1947, and that I last saw h alive on Dec. 18 1947

Immediate cause of death: Pulmonary Edema — Duration: 6 hrs.
Due to: Congestive Heart Disease — Duration: 1 mos.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. T. Cole M. D.
Address 6014 York Road Date signed 12-18-47.

VS 150

658146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30P

Registered No. 658146

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution City Hospital 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5805 Osborn Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel McDuffy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-7- 1912

8. AGE: Years 35 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Roanoke Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Industrial

FATHER
12. Name
13. Birthplace Va

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Fanny McDuffy
(b) Address 114 S. Broad St

17 (a) (Burial, cremation, or removal) (b) Date thereof DEC 20 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel
Location Baltimore

18 (a) Funeral director A. Hartley
(b) Address 1 E. Lanvale St

19 (a) DEC 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/47 19..., at 11:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cerebrovascular disease

Due to Hypertensive heart disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G58147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1780 Brookview Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Anna (Hotowitzki) Kopyscianski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife (Unknown) Living

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
C. 80			hr. min.

9. Birthplace Galicia - Europe (Town, county, and state)

10. Usual Occupation None

11. Industry or business -

FATHER 12. Name (Unknown) Conderal Kotarzyk

13. Birthplace

MOTHER 14. Maiden Name (Unknown) Mary Gut

15. Birthplace

16 (a) Informant Mrs. Joe. Zarchalk

(b) Address 1780 Brookview Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)

(c) Cemetery or crematory

Location Kensington, Md.

18 (a) Funeral director Lilly & Zeiler Inc.

(b) Address 403 S. Wolfe St.

19 DEC 19 1947 (Date Rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18 1947 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18 1947 to 12-18 1947 and that I last saw her alive on 12-18 1947

Immediate cause of death	Duration
Massive intraventricular hemorrhage	
Due to Hypertensive C V D.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M. D.

Address 1400 N. Caroline St Date signed 12-18-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C58148 B.C. 1952 / 1576 E

Registered No. C58148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL [52
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 McKean Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Geisler
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-27-47

8. AGE: Years | Months: 4 | Days: 27 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER — 12. Name George Geisler
13. Birthplace Mass.

MOTHER — 14. Maiden Name Marian Craven
15. Birthplace Ga.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-47 (month) (day) (year)
(c) Cemetery or crematory Mem Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Charles F. Dill
(b) Address 1201 E. Fort Ave

19 DEC 19 1947 (Date rec'd by reg.) Wm. Livingston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1947, at 10 29 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26, 1947 to 1947, and that I last saw her alive on Dec. 17 1947

Immediate cause of death Cardio-respiratory failure — Duration

Due to Bronchopneumonia — 4 wks

Due to Cong. Heart disease (Hypertension arteriosclerosis) — 4 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Crigler, Jr. M. D.
Address Johns Hopkins Hosp Date signed 12-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

58149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. 58149

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave
(c) Hospital or institution:
St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 1717 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	M

6 (b) Name of husband or wife Chas. F. Brown
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Dec 30. 1898

8. AGE: Years	Months	Days	If less than one day
69	11	29	hr. min.

9. Birthplace Baltimore Co.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Pugsley (decd)
13. Birthplace Md

MOTHER
14. Maiden Name Isabel (decd)
15. Birthplace Md

16 (a) Informant Phone Emer 1944
(b) Address

17 (a) Burial (b) Date thereof 12/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Memorial Park

18 (a) Funeral director Chas F. Powell
(b) Address 2427 Edmondson Ave

19 (a) DEC 19 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19- 1947 at 4 15 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Dec 1947 to 19 Dec 1947, and that I last saw h[illegible] alive on 19 Dec 1947

Immediate cause of death	Duration
Respiratory Foilure	
Due to Uremia, Diabetes Mellitus	
Due to	
Other Conditions Cystocele, Rectocele	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury James E. Hamill M.D.

23. Signature James E. Hamill M. D.
Address St. Agnes Hosp. Date signed 19 Dec 47

VS 190

68150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓X 186a

Registered No. 68150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Lansdowne
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 Furiah Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E. Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Emma May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21-1875

8. AGE: Years	Months	Days	If less than one day
71	11	27	hr. min.

9. Birthplace Somerset Co. Md.
(Town, county, and State)
10. Usual Occupation Silk Spooler
11. Industry or business Laundry

FATHER
12. Name Barney T. Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Briley
15. Birthplace Md.

16 (a) Informant Mrs. Emma Jones
(b) Address 201 Furiah Ave.

17 (a) Burial (b) Date thereof 12/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) DEC 19 1947 (b) Huffington-Williams, M.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Dec 19 47 at 12:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Dec 1947 to 18 Dec 1947 and that I last saw h.. alive on 18 Dec 19 47.

Immediate cause of death: Subdural Hematoma Right.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 17 Dec 47

Major findings of operation: Subdural Hematoma Right.

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 17 Dec. 47 at 7:00 A. M
(c) Where did injury occur? Lansdowne (Balto) Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury Fall down stops at home

23. Signature [illegible] M. D.
Address St. Agnes. Hosp. Date signed

Subject to Approval of Med. Examiner X (18 Dec 47)

Dr. Thomas

658151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. 658151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3221 Bayonne Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3221 Bayonne Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amelia A. Wyant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Edward S. Wyant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26, 1873

8. AGE: Years 74 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business —

FATHER
12. Name Louis Fiend
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Leo Scharfe
(b) Address 3006 Uchodlae Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2047 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 DEC 19 1947 (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1947 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1947 to Dec 17 1947 and that I last saw h alive on Dec 17 1947

Immediate cause of death: Cardiac [illegible] Duration 24

Due to: Senile Endocarditis 7 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 515 Wilkens Ave Date signed Dec 19 1947

Huntington Williams, M.D.

058152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 058152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 27 T
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Cheeley Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ARTHUR F. ARMSTRONG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Katherine C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 14-1891

8. AGE: Years 56 | Months 9 | Days 4 | If less than one day .....hr. .....min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Lineman

11. Industry or business B.T. Co.

FATHER
12. Name Arthur F. Armstrong
13. Birthplace England

MOTHER
14. Maiden Name Harriett Thorne
15. Birthplace England

16 (a) Informant Mrs. Katherine Armstrong
(b) Address 2911 Cheeley Avenue

17 (a) Burial (b) Date thereof 12/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director L. Hyde
(b) Address 5305 Harford Rd -14-

19 (a) DEC 19 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1947, at 9 40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/18/47

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

058153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106a

Registered No. 058153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 N Broadway
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME HOWARD LINDSEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1867

8. AGE: Years	Months	Days	If less than one day
	3		....hr. ....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School DEC 17, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 19 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1947, at 12 45 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Acute tracheo-bronchitis
Malnutrition

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/15/47

058154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

Registered No. 058154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 630 S. Fremont Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME FRANK WHIRLS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
51			..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location. University Medical School DEC 17, 1947

18 (a) Funeral director. Commissioner of Health
(b) Address.....

19 (a) DEC 19 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1947, at 3.10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Cerebral hemorrhage
Due to.....
Other Conditions syphilitic aortitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature. Emil H. Rogen M.D.
Medical Examiner
Date signed 12-9-47

VS 181

83a

PRESS FIRM FLAT, WITH UNFADING INK. Enter correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658155 B.C J-96376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 658155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6hr
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore 30. (If outside city or town limits, write RURAL and give town)
(d) Street No. 743 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Wood.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 13, 1947.

8. AGE: Years	Months	Days	If less than one day
			6 hr. min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)

10. Usual Occupation NEWBORN.

11. Industry or business

FATHER
12. Name Abel Floyd William Wood.
13. Birthplace NEW KENT Co, Va.

MOTHER
14. Maiden Name Thelma MARIE Sabourn
15. Birthplace BALTIMORE, Md.

16 (a) Informant MRS. Thelma Wood.
(b) Address 743 WASHINGTON Blvd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Local place Hopkins Medical School DEC 16, 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) DEC 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1947, at 5-18 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1947 to 12/14 1947, and that I last saw him alive on 12/14 1947.

Immediate cause of death	Duration
Pulmonary edema	
Due to Tetralogy of Fallot.	
Due to	
Other Conditions Large Congenital ventricular defect	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon H. Bishop M.D.
Address Franklin Square Hosp. Date signed 12/13/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658156

CM. 115673

13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
2 (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 274 N. Exeter ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12 -1900

8. AGE: Years	Months	Days	If less than one day
47	1	27	hr. min.

9. Birthplace ALA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ALA.

MOTHER
14. Maiden Name Emma ?
15. Birthplace ALA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 15 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 9 - 1947 at 6.35A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 -5 -- 1947 to Dec. 9 - 1947 and that I last saw h. 1m alive on Dec. 9 -1947.

Immediate cause of death	Duration
Tuberculosis of the lungs far-advanced Bilateral	1+ years
Due to	
Due to	
Other Conditions generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas W. Parks M. D.
Address Balt City Hosp Date signed 12-10-47

658157

AB-89190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

658157 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 41 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Earl Smith ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?

8. AGE: Years	Months	Days	If less than one day
96?			hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Edward Smith (D
13. Birthplace N.C.

MOTHER
14. Maiden Name Hattie Murphy
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 15 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 19 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2- 1947, at 7.55AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28 1944 to 12-2- 1947 and that I last saw h. im alive on 12-2- 1947

Immediate cause of death	Duration
Bronchopneumonia	wks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. C. Robinson Jr. M. D.
Address Balt City Hosp Date signed 12/17/47

VS 150 NOT To be Approved by the Medical Examiner

X

G58158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G58158

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street (30)
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 E. Hughes Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Allen

3 (b) If veteran, name war — | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ? Unknown
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 19, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 19 1947 (b) Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/47 19 , at 2 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1947 to 12/15 1947 and that I last saw him alive on 12/15 1947.

Immediate cause of death Carcinoma of The Sigmoid ? Metastasis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ca. of Sigmoid Metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Hillson M. D.
Address South Balto Gen Date signed 12/16

658159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. 658159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME York Sanders Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	col	Married

6 (b) Name of husband or wife Clara Chapman
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1898

8. AGE: Years	Months	Days	If less than one day
49	2	22	hr. min.

9. Birthplace Greenville, NC
(Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name York Sanders Clark
13. Birthplace NC

MOTHER
14. Maiden Name Delane ?
15 Birthplace NC

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Dec 22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem
Location

18 (a) Funeral director Mrs. Ruth A. Elliott, Dft
(b) Address 1129 N. Carlton St

19 (a) DEC 19 1947 (b) Huntington Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 19 47 at 11:25AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1947, to Dec. 17 19 47, and that I last saw him alive on Dec. 17 19 47.

Immediate cause of death	Duration
Carcinoma of left lung with metastasis to heart and other viscera	UNKNOWN
Due to (2) Hemopericardium due to metastatic tumor	UNKNOWN
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/17/47

VS 150

58160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

460

Registered No. 58160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. Va. (b) County Balt.
(c) City or town Baltimore City (Portage)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1673 Yakona Road (If rural give location) R.D.#1, Box 106
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. B Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/25/88

8. AGE: Years	Months	Days	If less than one day
59	1	24	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation engineer
11. Industry or business Koppers Coal Co.

FATHER
12. Name John Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Herman
15. Birthplace Germany

16 (a) Informant Work Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22 (month) (day) (year)
(c) Cemetery or crematory St Bartholmew
Location Wilmore Pa.

18 (a) Funeral director Harry H Hicks
(b) Address 401 Edmondson ave

19 (a) DEC 19 1947 (b) (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19/47 19..., at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1947 to Dec 19 19 47 and that I last saw h i M alive on Dec 19 19 47.

Immediate cause of death Pneumonia — Duration

Due to Post-operative resected Esophagus

Due to Carcinoma cardia metastases.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/13/47.

Major findings of operation: Ca of esophagus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H B Scott M. D.
Address Mercy Date signed 12/19

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~658161~~ LW 115863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

Registered No. 658161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles ~~Haskins~~

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 50 ? | Months | Days | If less than one day: hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22-47 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto. Md.

18 (a) Funeral director Cleary & Wilson
(b) Address 1000 Broadway Ave

19 (a) DEC 19 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16- 19 47, at 9:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13- 19 47 to 12-16- 19 47 and that I last saw h IM alive on 12-16- 19 47.

Immediate cause of death: Tuberculous Meningitis — Duration: 5 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius Stolt, Jr. M. D.
Address Balt. City Hosp. Date signed 12/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

658152 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd & Calvert Sts
(c) Hospital or institution Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4dy.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3603 Alloway Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Denny Barnes
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Mrs. Ada C. Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1882

8. AGE: Years	Months	Days	If less than one day
65	7	5	hr. min.

9. Birthplace Pasquotank Co. N.C. (Town, county, and state)
10. Usual Occupation Office Mngr. Dist. Mgr.
11. Industry or business Bldg

FATHER
12. Name Frank M. Barnes
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Flaires
15. Birthplace Maryland

16 (a) Informant Mrs. Ada C. Barnes
(b) Address 3603 Alloway Ave. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-47 (month, day, year)
(c) Cemetery or crematory Levelgreen Cemetery
Location Harford Co. Md.

18 (a) Funeral director H. Madison Mitchell
(b) Address Havre de Grace Md.

DEC 19 1947 (Date Rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19-47 19 at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13- 1947 to 12-19 1947 and that I last saw h[illegible] alive on 12-19 1947

Immediate cause of death [illegible]

Due to Cerebral Hemorrhage

Due to

Other Conditions Hypertension Arteriosclerosis Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration
2 wk.
2 yr.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. R. Freeman Jr. M. D.
Address Union Memorial Hosp. Date signed 12-19-47

VS 150

658163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 947

Registered No. 658163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 Gorsuch Ave
(c) Hospital or institution: 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Gorsuch Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emil Kiesewetter

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-8995

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Josephine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26 1878

8. AGE: Years	Months	Days	If less than one day
69	9	23	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Baker

FATHER
12. Name (Unknown) Kieswetter
13. Birthplace Germany

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Francis H. Kiesewetter
(b) Address 1111 Gorsuch Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 20 1947 (Date received by registrar) (b) Funeral for Wilson M.E.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19th 1947, at 10 15 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1947 to Dec. 19 1947 and that I last saw him alive on Dec 19, 1947.

	Duration
Immediate cause of death: Coronary Occlusion	6 mos.
Due to: Generalized Arteriosclerosis	2 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest Lewis, M.D.
Address 1601 N. Broadway Date signed 12/19/47 M.D.

X

58164 ✓ 658164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3620 - Robert Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian May KRESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: John C. Kress

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8th 1909

8. AGE: Years 38 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Harry Quigley
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ida Siegmund
15. Birthplace Balto. Md.

16 (a) Informant John C. Kress
(b) Address 3620 Roberts Place

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 20 1947 (Date rec'd by registrar) (b) Huntington & Williams, M

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1947 at 4:17 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Left subdural hemorrhage
Edema of lungs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658165 BC# 2-94167 — AB-115917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 658165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15-1947

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Wright
13. Birthplace ?

MOTHER
14. Maiden Name Ida Mae Wright
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof 12-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ or crematory B.C.H. 9.00 AM
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) DEC 20 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 19 47 at 1.37 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1947 to 12-17 1947 and that I last saw h im alive on 12-17 1947

Immediate cause of death Premodarity — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Premodarity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold H Becker M. D.
Address Balto City Hosp Date signed 12/18/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58166 LW 115891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160A

Registered No. G58166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 161
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 N. Carrolton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boyb Henderson (Nannie)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-14-47

8. AGE: Years | Months | Days: 2 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander
13. Birthplace S.C.

MOTHER
14. Maiden Name Nannie Blackwell
15. Birthplace S.C.

16 (a) Informant B.C.H.Records
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12-18-47 (month) (day) (year)
(c) Cemetery or crematory B.C.H. At (9.00 AM
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) DEC 20 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16 19 47, at 7:43 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 19 47 to 12-16 19 47, and that I last saw him alive on 12-16 19 47.

Immediate cause of death: Prematurity — Duration: 2 days

Due to

Due to

Other Conditions: Intracerebral bleeding
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arnold H Becker M. D.
Address Balto City Hosp Date signed 12/18/47

VS 150

159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 058167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 W Barre
(c) Hospital or institution: 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 W Barre St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Robi

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1880

8. AGE: Years 67 | Months 9 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sam Parker
13. Birthplace Va

MOTHER
14. Maiden Name Jamie Carter
15. Birthplace Va

16 (a) Informant Martha Streets
(b) Address Washington D.C

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Balto City

18 (a) Funeral director Isaac L. Brown & Son
(b) Address 108 W Montgomery St.

19 (a) DEC 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/1947, at 9 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1947 to Dec 17 1947, and that I last saw her alive on Dec 13 1947.

	Duration
Immediate cause of death: Chronic Hypertensive-Cardiac Disease	unknown
Due to: Age & patient ?	
Due to:	
Other Conditions: Acute Neuritis	3 Wks

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John W Haines M. D.
Address 507 W. Hamburg St Date signed 12/19/47

X

658168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111B

Registered No. 658168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 6815 Multhorp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Adams (Amos White)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 250-28-3415

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/17/1926

8. AGE: Years 31 | Months 1 | Days 20 | If less than one day ..... hr. 9 16 min.

9. Birthplace L C
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Amos White
13. Birthplace L C

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Headspeth
(b) Address 613 Exeter St.

17 (a) Burial (b) Date thereof 12/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co., Md

18 (a) Funeral director Isaac L Brumbley
(b) Address 106 W Montgomery St

19 (a) DEC 20 1947 Hunting for Wm. Adams, White
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1947, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Exg & Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Helfrich M.D.
Medical Examiner.
Date signed Nov 16, 1947

PLEASE WRITE PLAINLY, WITH ONE READING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. 658169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 S. Charles St.
(c) Hospital or institution: ——— 232
(d) Length of stay in hospital or inst. (yrs., mos., or days) ———
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ———
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 S. Charles St. (If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country ———

3 (a) FULL NAME Annie E. C. Ward

3 (b) If veteran, name war ———
3 (c) Social Security Account No. ———

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Alfred Ward (Deceased) 6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) December 8, 1881

8. AGE: Years 66 | Months — | Days 10 | If less than one day ——— hr. ——— min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name John Koch
13. Birthplace Germany

MOTHER 14. Maiden Name Christina Buesler
15. Birthplace Germany

16 (a) Informant Wm. Koch (Brother)
(b) Address 1609 S. Charles St. Balto. Md.

17 (a) Burial — (b) Date thereof (burial, cremation, or removal) Dec. 20 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director T. Howard Evans
(b) Address 400 S. Charles St., Balto. 2, Md.

19 DEC 20 1947 (b) Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Thur., Dec. 18, 1947, at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1947 to Dec 18 1947 and that I last saw h[illegible] alive on Dec 17 1947

Immediate cause of death	Duration
(a) Coronary Thrombosis	2 days
Due to Senile Psychosis	6 yr
Due to Chr. Nephritis	6 yr
Other Conditions Hypertension	6 yr

(Include pregnancy within 3 months of death)
Date of operation ———
Major findings of operation: ———
of autopsy ———

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ———
(b) Date of occurrence ——— at ——— M
(c) Where did injury occur? ——— (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ——— While at work? ——— (Specify type of place)
(e) Means of injury ———

23. Signature J. Howard Evans
Address 400 E. Preston St. Date signed 12/19/47

VS 150

X

658170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. 658170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (years, months or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore - 25 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 15th Ave (If rural give location) ?
(e) Citizen of foreign country? ? (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS F. MINARIK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-1883

8. AGE: Years	Months	Days	If less than one day
64	10	17	hr. min.

9. Birthplace Europe (Town, county, and state)

10. Usual Occupation Unemployed
11. Industry or business (Transient worker)

FATHER
12. Name Joseph Minarik
13. Birthplace Europe

MOTHER
14. Maiden Name Anna Jezek
15. Birthplace Europe

16 (a) Informant Magaret Minarik
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Gov Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3964 Hanover St

19 DEC 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19-1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18-1947 to 12-19-1947, and that I last saw h[illegible] alive on 12-19-1947

Immediate cause of death: Respiratory failure, acute — Duration

Due to: Ascites and chronic passive congestion, liver — ? days

Due to: Portal hepatic occlusion — ? Months

Other Conditions: Cirrhosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: If Portal cirrhosis If thrombotic pneumonia
of autopsy: Confirm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Kilton M.D.
Address [illegible] Date signed 12/14/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~58171~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH, 13B

Registered No. 58171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: City Hosp. 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 S. Ann Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME WANDA Kacoctha

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 34 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business —

FATHER
12. Name Francis Kacocha
13. Birthplace Mass

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Rose Kacocha
(b) Address 2011 Linden Ave

17 (a) Burial (b) Date thereof 12 20 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Philip Jennings Sons
(b) Address 2024 Orleans st

19 DEC 20 1947 Huntington Williams
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/47 19..... at 7:45 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to HER death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature John L. Lewis M.D.
Medical Examiner.
Date signed 12/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658172 B 7674 NO166 ✓ 107 ✓ 658172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital 14- D.O.X.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LINDA L. NAILL ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1st 1947

8. AGE: Years	Months	Days	If less than one day
	2	15 17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Rockford Naill
13. Birthplace New Windsor Md.

MOTHER
14. Maiden Name Louise F. Comley
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Mary Brooks
(b) Address 361 Vista Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery or crematory Carroll Chapel
Location Chestnut Ridge Md.
18 (a) Funeral director John J. Logan & Son
(b) Address 901-03 Hollins St.
19 (a) DEC 20 1947 (Date received by registrar) (b) Beatrice Williams (Signature of registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1947, at 5.15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Logan M.D.
Medical Examiner.
Date signed 12-18-47

X

3100 Keswick Rd. 1152 St Paul St.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

Registered No. 058173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3100 Keswick Rd
(c) Hospital or institution: 13-S
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Keswick RD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert H Arnold

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20 188[illegible]

8. AGE: Years: 61 | Months: 9 | Days: 29 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Groceryman

FATHER — 12. Name Levi Arnold
13. Birthplace Md

MOTHER — 14. Maiden Name Francis Patterson
15. Birthplace Md

16 (a) Informant Evelyn M Shriever
(b) Address 3100 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk
Location Baltimore Md

18 (a) Funeral director Frank H Sieck
(b) Address 814 N 36 St.

19 (a) DEC 20 1947 (Date rec'd by registrar) Herington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1940 to 12-19 1947 and that I last saw him alive on 12-19 1947

Immediate cause of death	Duration
Myocardial Failure	
Due to Cerebral Hemorrhage	
Due to Hypertension Vascular	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address Date signed

VS 150

658174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

658174 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 560 Orchard St.
(c) Hospital or institution: 17
(d) Length of stay in hospital or instt. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 560 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theodore Jones

3 (b) If veteran, name war: W. W. I
3 (c) Social Security Account No. 218-09-9298

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1897

8. AGE: Years	Months	Days	If less than one day
50	1		hr. min.

9. Birthplace Salisbury, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jacob Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ann Barkley
15. Birthplace

16 (a) Informant Harriette Desfillings
(b) Address 560 Orchard St.

17 (a) (Burial, cremation, or removal) (b) Date thereof Dec 19 1947 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Adolphus Halsted
(b) Address 918 Druid Hill Ave

19 Dec 19 1947 C. B. Stanfield Registrar
(Date received by City Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1947 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 17 1947 and that I last saw him alive on Dec 16 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to: Pulmonary Tuberculosis	7
Due to: Sarcoma	1
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Spencer L. Jones
Address 1707 Linden Ave Date signed 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

058175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Windsor Ave.
(c) Hospital or institution: Convalescent Home 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5346 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jane E. McClure

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Louis R. McClure
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1869 | 77

8. AGE: Years 73 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name George Heath
13. Birthplace Va.

MOTHER
14. Maiden Name
15. Birthplace Md.

16 (a) Informant O. Raymond McClure
(b) Address 5346 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O McCausland & Sons
(b) Address 1900 Eutaw Place

19 (a) DEC 20 1947 (Date rec'd by registrar) (b) [illegible] for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1947, at 10¹ M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1947, to Dec 18 1947 and that I last saw h~~er~~ alive on Dec 18 1947

Immediate cause of death: (a) Chron Cardiac Failure — Duration

Due to: Chronic Hypertension

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Sengretti M. D.
Address Windsor Court Apts. Date signed 12/19/47

7 - 9 AM Dr. Sengretti - 1729 W. Lombard

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

158176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 158176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 Hollen Road
(c) Hospital or institution: none 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Hollen Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Deborah F. Blackburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Charles P. Blackburn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1863

8. AGE: Years 84 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Wilmington, Del. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name William Ferris
13. Birthplace Wilmington, Del.

MOTHER
14. Maiden Name Mary Wetherald
15. Birthplace Wilmington, Del.

16 (a) Informant Mary F. Blackburn
(b) Address 407 Hollen Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery ~~crematory~~ Friends
Location Harford Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 DEC 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 23, 1920 to Dec. 17, 1947 and that I last saw h[illegible] alive on Dec. 17, 1947.

	Duration
Immediate cause of death: Cardiac failure	6 Mos
Due to: Arteriosclerosis about	10 yrs
Due to: Interstitial Nephritis	8 yrs
Other Conditions: Aortic thickening	July 5 1947

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/12
(a) Accident, suicide, or homicide accident
(b) Date of occurrence July 5, 1947
(c) Where did injury occur? 407 Hollen Rd. M
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Slipped & fell down front steps to pavement

23. Signature Howard Bostick M. D.
Address 2125 Maryland Ave. Date signed 12/19/47

Howard J. Bostick, M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 658177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 Ashland Court
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Ashland Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Schaible (Theresa Scheible)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 219-10-4289

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29th., 1874

8. AGE: Years 73 | Months 10 | Days 20 | If less than one day ####### hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Char work

11. Industry or business Building Asso.

FATHER
12. Name Adam Schaible
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia ?
15. Birthplace Unknown

16 (a) Informant Mrs. Marie Schneider
(b) Address 2907 North Point Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location Belair Road

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) DEC 20 1947 (Date received by Registrar) (b) Lucy for Williams, M.D. Registrar

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19/47 19 ; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1947 to Dec 19 1947, and that I last saw h[illegible] alive on Dec 17 1947.

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions: Diabetes Mellitus, Arteriosclerosis, Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Schneider
Address 1337 S. Charles St. Date signed 12/19/47

94A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. 158178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 28-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County ~
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 WESTGATE RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM A. BARNES
3 (b) If veteran, name war —
3 (c) Social Security Account No. 214-03-6970
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife VILA V. nee GRAHAM
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) AUG. 27, 1885
8. AGE: Years 62 | Months 3 | Days 21 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Construction Supt.
11. Industry or business Welsh Construction Co.
FATHER 12. Name BALTIMORE, MD.
FATHER 13. Birthplace WILLIAM A BARNES.
MOTHER 14. Maiden Name ~~ADDIE~~ ANNA A WYABLE
MOTHER 15. Birthplace BALTIMORE, MD.
16 (a) Informant MRS. VILA V. BARNES
16 (b) Address 427 WESTGATE RD.
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
17 (c) Cemetery or ~~crematory~~ LOUDON PARK
Location Balto. MD.
18 (a) Funeral director WM J. TICKNER & SON INC
18 (b) Address North & Pa. Aves. Balto. MD.
19 DEC 20 1947 (Date rec'd by Registrar) (b) Certified by Wm. J. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1947 at 1155 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1947 to 12/18 1947 and that I last saw h. A. alive on 12/18 1947.

Immediate cause of death	Duration
MYOCARDIAL INFARCTION	3 days
PULMONARY EDema	3 hours
Due to CORONARY SCLEROSIS & CORONARY OCCLUSION	
Due to	
Other Conditions GENERALIZED ARTERIO SCLEROSIS (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harold Sussman M.D.
Address Sinai Hospital Date signed 12/19/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 132

G58179 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 S. ROSEDALE St.
(c) Hospital or institution: 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County ✓
(c) City or town BALTIMORE, MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 S. ROSEDALE St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT L. SHIPLEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	WIDOWED

6 (b) Name of husband or wife IDA V. SHIPLEY
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MAY 12, 1864

8. AGE: Years	Months	Days	If less than one day
83	7	7	..... hr. ..... min.

9. Birthplace A. A. Co., MD. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name RICHARD A. SHIPLEY
13. Birthplace A. A. Co.

MOTHER
14. Maiden Name AGNUS QUAILL
15. Birthplace BALTIMORE MD.

16 (a) Informant MRS. A. M. McCLELLAND
(b) Address 14 S. ROSEDALE St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery or crematory FRIENDSHIP
Location ANN A. COUNTY

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address NORTH & N. AVES., BALTO., MD.

19 DEC 20 1947 (Date rec'd by Registrar) Courtesy for Williams MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Dec~~ 12/19 1947, at ~ A M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 15 1947 to DEC 19 1947 and that I last saw h~~i~~m alive on Dec. 19 1947.

Immediate cause of death	Duration
Hemorrhage from Lungs —	2 days.
Due to	
Due to	
Other Conditions Nephritis & Prostatitis — (Include pregnancy within 3 months of death)	6 mos.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. L. Back Jr. M. D.
Address Lutherville Date signed 12-19-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59A

Registered No. 058180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4212 ELDERON AVE
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4212 ELDERON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOIS MAY EVERNGAM

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 30, 1930

8. AGE: Years	Months	Days	If less than one day
17	3	19	hr. min.

9. Birthplace BALTO; MD. (Town, county, and state)
10. Usual Occupation STUDENT
11. Industry or business —

FATHER
12. Name WM. H. EVERNGAM
13. Birthplace BALTO; MD.

MOTHER
14. Maiden Name OLEITA McCONKEY
15. Birthplace BALTO, MD.

16 (a) Informant FATHER
(b) Address SAME

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE, BALTO CO. MD

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves. Balto, MD

19 (a) DEC 20 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19/47, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on Dec. 19 19 47.

Immediate cause of death	Duration
Pernicious Vomiting	2 weeks.
Dehydration & Acidosis	
Due to Rheumatoid Arthritis	6 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Howard Smith M.D.
Address 11 E. Chase St. Date signed 12/19/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(58181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 58181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1820 E. 31st. Street
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 E. 31st Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY WILSON CRONHARDT

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1869

8. AGE: Years	Months	Days	If less than one day
78	1	25	hr. min.

9. Birthplace Old Point Comfort, Va. (Town, county, and state)
10. Usual Occupation ----
11. Industry or business ----

FATHER
12. Name Allen Wilson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Clara Newman
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Jesse C. Edwards
(b) Address 1820 E. 31st Street, Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Greenmount Cemetery
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves; Balto, Md.

19 (a) DEC 20 1947 (Date rec'd by registrar) (b) Tunstall Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1947, at 4:00P M

21. I certify that death occurred on the date above stated, that I attended deceased for the last ~~of~~ Dec, 19..., and that I last saw h~~e~~r alive on 12/19 1947.

Immediate cause of death	Duration
Coronary sclerosis	2 yrs
Due to Bronchitis	4 yrs
Due to Senile	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Cassell M.D.
Address 3908 Woodland Ave Date signed 12/20/47

X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

058182 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 N Dallas st
(c) Hospital or institution: 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 N. Dallas st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Jordan
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1873
8. AGE: Years 74 | Months Dec | Days 7 | If less than one day hr. min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Retired Farmer

FATHER 12. Name Shepherd Jordan
13. Birthplace Va

MOTHER 14. Maiden Name Martha Powell
15. Birthplace Va

16 (a) Informant William Mc Jordan
(b) Address 131 Dallas st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/37 (month) (day) (year)
(c) Cemetery or crematory Campbell Chapel
Location Virginia

18 (a) Funeral director Hall & Williams
(b) Address 1515 Mc Elderry

19 DEC 20 1937 (Date rec'd by Registrar) by Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1937, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1937 to Dec 18 1937 and that I last saw h[illegible] alive on 19

Immediate cause of death: Cerebral Hemorrhage — Duration 3 days
Due to Hypertensive Cardio Vascular Disease
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. K. Williams
Address 1222 N. Carrollton Date signed 12/19/37 M. D.

VS 150

X

58183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1317

Registered No. 58183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 WILLIAM ST.
(c) Hospital or institution: 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 WILLIAM ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KATHERINE NEHMSMANN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife HENRY NEHMSMANN

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) SEPT 26 - 1881

8. AGE: Years 66 | Months 2 | Days 23 | If less than one day ____hr. ____min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business AT HOME

FATHER 12. Name JOHN C OSTERHAUS

13. Birthplace BALTIMORE MD

MOTHER 14. Maiden Name MARGARET PEISTER

15. Birthplace BALTIMORE MD

16 (a) Informant MRS JOHN KEITH

(b) Address 133 E FORT AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 22 47 (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS

Location A A Co.

18 (a) Funeral director BERNARD C HEALY

(b) Address 121 E WEST ST

19 (a) DEC 20 1947 (Date rec'd by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1947, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947 to Dec 19 1947, and that I last saw h[illegible] alive on 12/19 1947.

Immediate cause of death: Uremia Coma. — Duration: 2 days.

Due to: Chronic Nephritis — 4 mos.

Other Conditions: Arterial Hypertension — 1 year.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address 1079 Fulton N Date signed 12/20/47 M. D.

658:84

658:84

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83A

Registered No. _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 847 S PACA ST.
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) _____
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County _____
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 847 S PACA ST.
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME EMMA V DAGLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEM.

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: FREDERICK DAGLER

6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) OCT 6 1884

8. AGE: Years 63 | Months 2 | Days 13 | If less than one day _____ hr. _____ min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business AT HOME

FATHER
12. Name EDWARD SHELDON
13. Birthplace BALTO MD

MOTHER
14. Maiden Name EMMA BURKHEAD
15. Birthplace BALTO MD

16 (a) Informant MRS EDNA MAY MOYER
(b) Address 847 S PACA ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 23-47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK RD

18 (a) Funeral director BERNARD C HARKINS
(b) Address 121 E WEST ST.

19 DEC 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1947, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1947 to 12-19 1947 and that I last saw h-e alive on 12-19 1947.

Immediate cause of death	Duration
(a) Acute Cardiac Failure	1da
Due to (b) Cerebral Hemorrhage	
Due to (c) Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Joseph G Laurentis M. D.

Address 6 E Lexington St Date signed 12/19/47

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 058185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c). Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 Division St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES BUTLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1896

8. AGE: Years	Months	Days	If less than one day
51 53	1	11	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business Beth. Steel Co

FATHER
12. Name Robert Butler
13. Birthplace Md

MOTHER
14. Maiden Name Hall
15. Birthplace Md

16 (a) Informant Octavia Brafton
(b) Address 1114 N. Eutaw Ave

17 (a) Burial (b) Date thereof 12-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Cathedral
Location Baltimore, Md

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) DEC 20 1947 (b) Huntington Mills Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19-1947, at 4:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12-1947 to 12-19-1947 and that I last saw him alive on 12-19-1947

Immediate cause of death	Duration
Respiratory failure, acute	
Due to Intracerebral hemorrhage, atelectasis	9 days
Due to Hypertensive Cardio-vascular disease	unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Hemorrhage, intracerebral
of autopsy: at ant. capsule, cyst wall
Ruptured at lenticulostriate

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Charles R. MacDonald M.D.
Address 1213 Light St. Date signed 12-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

658186 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State MDs. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Ensor St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Archie Jenkins

3 (b) If veteran, name war
3 (c) Social Security Account No. 218-05-9742

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Nora Ferguson Jenkins
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) July 4, 1870

8. AGE: Years	Months	Days	If less than one day
77	5	3/4	hr. min.

9. Birthplace Frostburg, Maryland (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Merchant Seaman

FATHER
12. Name Richard Jenkins
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Emma Thomas
15 Birthplace Pennsylvania

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. City, Md.

18 (a) Funeral director Charles R Law
(b) Address 802 Madison Ave.

19 DEC 20 1947 (Registered by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH December 18 19 47 at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 19 47, to Dec. 18 19 47, and that I last saw h. alive on Dec. 18 19 47

	Duration
Immediate cause of death Carcinoma left lung (lower lobe)	1 year
Due to Metastasis to mediastinum pericardium and myocardium	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature John L. Wilson
JOHN L. WILSON, Senior Surgeon
Address Clinical Director Date signed 12/18/47 M.D.

VS 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

158187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. 158187

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2730 Wilkens) Ave.
(c) Hospital or institution: 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2730 Wilkens) Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Snyder. Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-0940

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife Marie E. Snyder.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 8-1882

8. AGE: Years 65 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name John Snyder.
13. Birthplace Baltimore - Md.

MOTHER 14. Maiden Name Elizabeth Ruehling
15. Birthplace Germany.

16 (a) Informant Mr. William F. Snyder Jr.
(b) Address 524 Hurley Ave

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Dec. 22/47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

19 (a) DEC 20 1947 (Date received by Registrar) (b) Thurlington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December, 18- 1947; at 10.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1947 to 12/18 1947 and that I last saw h alive on 12/18 1947.

Immediate cause of death Coronary thrombosis — Duration 4 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Wilkes M. D.

Address 2730 Wilkens Ave Date signed 12/19/47

x ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 181

58188 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 264
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Kresson Street.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME Charles B. RUGEMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maria Pugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Boiler Maker
11. Industry or business Penn R.R.

FATHER
12. Name John A. Rugemer
13. Birthplace ?

MOTHER
14. Maiden Name ? Cyppola
15. Birthplace ?

16 (a) Informant Geo. W. Rugemer
(b) Address 829 Glenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)
(c) Cemetery or crematory Maryland Mem.
Location Maryland Rd.

18 (a) Funeral director Wiley & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 (a) DEC 20 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19, 1947, at 10:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSE OF DEATH
Extensive 1st, 2nd, and 3rd degree
BURNS, covering about
Due to 85% of the body surface.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-19-47 at 10 P M 26-4
(b) Where did injury occur? Orangeville Round House Penna. R.R. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Biler explosion

23. Signature George H. Merrill M.D. Medical Examiner.
Date signed 12/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58189 GM. 96361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186A

Registered No. G58189

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals. 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Years
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 S. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Rohloff Or Anna Rohnoff

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14 1868 ?

8. AGE: Years 79 ? | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-47 (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location O'Donnell St.

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 405 S. Bond St.

19 (a) DEC 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 - 1947, at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9- 29 - 1945 to Dec. 13 1947 and that I last saw her alive on Dec. 13 1947.

Immediate cause of death Bronchopneumonia — Duration 2 wks

Due to Inter-trochanteric fracture of femur, rt — 3 mos

Due to — 3 wks

Other Conditions Decubitus ulcers of sacrum + buttocks

(Include pregnancy within 3 months of death)

Date of operation 9/22/47

Major findings of operation: Inter-trochanter fracture

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9/29/47 at 9 A.M.
(c) Where did injury occur? Balt. City Hosp. Baltimore Maryland (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Infirmary While at work? No (Specify type of place)
(e) Means of injury Fell down stairs

23. Signature Gordon Craft

Address Balt. City Hosp. Date signed 12/19/47 M. D.

VS 150

To Be Approved By Medical Examiner Howard J. Anderson, M. D.

58190 BC 09736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 157D

058190 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Barnes St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROGER JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-7-46 NS

8. AGE: Years	Months	Days	If less than one day
2			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Kinwood Johnson
13. Birthplace Va.

MOTHER 14. Maiden Name Rosie Johnson
15. Birthplace Va.

16 (a) Informant Rosie Johnson
(b) Address 1713 Barnes St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 20 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto. County Md.

18 (a) Funeral director Mrs. N. A. Elliott's Daughter
(b) Address 1129 N. Caroline St.

19 (a) DEC 20 1947 (Date received by reg.) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19, 1947, at 8 a. M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Microcephalus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Hayer M.D. Medical Examiner
Date signed 12-20-47

X

058191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

058191 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 Cambria St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Cambria St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Married

6 (b) Name of husband or wife William Watkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Brooklyn, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry T. Brooks
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine Hammond.
15. Birthplace Md.

16 (a) Informant William Watkins
(b) Address 104 Cambria St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) DEC 20 1947 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 19 47 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death Carcinomatosis — Duration

Due to Cirrhosis of Breast

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 743 Madison Ave Date signed 12/19/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658192
AB-115612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. 658192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Elliott

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife: Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23- 1873

8. AGE: Years	Months	Days	If less than one day
74	5	24	hr. min.

9. Birthplace Maryland - Basto (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Brant (D
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Layman (D
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospit
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 22 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd
18 (a) Funeral director Martin W. C. Diggel
(b) Address 37 S. Ann St.

19 (a) DEC 29 1947 (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Dec. 19- 19 47, at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10- 19 47 to 12-19 19 47 and that I last saw her alive on 12-19 19 47

Immediate cause of death Uremia — Duration 1 wk.

Due to renal shutdown from fatigue from gangrene of foot — wks

Due to Diabetes mellitus — wks

Other Conditions Arteriosclerosis, cerebral hemorrhage, pneumonia — yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: (nephrosclerosis) renal damage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt City Hosp. Date signed 12/29/47

X

658193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 658193

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 16 hr

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Covington Va
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Johns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife J. M. Johns

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2-1888

8. AGE: Years 59 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Sylvester Robinson
13. Birthplace Va

MOTHER
14. Maiden Name Margaret Harris
15. Birthplace Va

16 (a) Informant Mr. John Johns
(b) Address Curtis Creek - P.O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/47 (month) (day) (year)

(c) Cemetery or crematory Stonewall Jackson Cem
Location Lexington Va

18 (a) Funeral director Walter Schilling
(b) Address 3914 Hanover Ave Richmond Va

19 DEC 20 1947 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Dec 1947, at 4 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Dec 1947, to 20 Dec 1947, and that I last saw h.. alive on 20 Dec 1947

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertensive C.V. Disease	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.

Address Franklin Sq. Hosp. Date signed 20 Dec '47

921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

Registered No. G58194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 E. Robinson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 E. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary B. Schoeberlein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife John B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8 1893

8. AGE: Years	Months	Days	If less than one day
54	-	10	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name Jacob Zozniah
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs John B. Schoeberlein
(b) Address 1100 E. Robinson St.

17 (a) Burial (b) Date thereof Dec. 21 / 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Cem.
Location Highlandtown

18 (a) Funeral director Stephen J. Thornton
(b) Address 1000 S. Kenwood Ave

19 (a) Date received by local registrar Dec. 22 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/47 19 4:15 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/29 19 to 12/18 1947.
and that I last saw h- alive on 12/17/47.

Immediate cause of death	Duration
(a) Myocardial degeneration	4 yrs
Due to (b) Arteriosclerosis	2 mo
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Herrmann M.D.
Address 1706 E. 33rd St Date signed 12/18/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658195 444598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 157E

Registered 658195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Beaumont (If outside city or town limits, write RURAL and give town)
(d) Street No. 2250 South St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Berly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-19-41

8. AGE: Years 6 | Months 11 | Days - | If less than one day hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harold Berly
13. Birthplace Texas

MOTHER 14. Maiden Name Eva Lee Derr
15. Birthplace Texas

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Beaumont Texas

18 (a) Funeral director Geo. McInnis & Son
(b) Address [illegible]

19 DEC 21 1941 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 19 - 1947 at 9 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16-1947 to 12-19-1947 and that I last saw him alive on 12-19-1947.

Immediate cause of death	Duration
CONGENITAL HEART DISEASE	Life
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12-15-47

Major findings of operation: TRANSPOSITION OF GREAT VESSELS

of autopsy: SAME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Richard C. Coa
Address Johns Hopkins Hosp Date signed 12-20-47

VS 150

058196 BALTIMORE CITY HEALTH DEPARTMENT 058196

CERTIFICATE OF DEATH 94A

Registered No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Mem. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Randallstown
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 103 Briarton Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Nan C. Madison NAN. C. MADISON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Robert P. Madison
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1875

8. AGE: Years 72 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name H. D. Howell
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Catherine Howell
15. Birthplace Maryland

16 (a) Informant Mrs. Harold N. Hubbard
(b) Address Randallstown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22 1947
(month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Balto Co Md

18 (a) Funeral director E. Gillis Lamasney
(b) Address 4510 Liberty Heights Ave

19 (a) 1947 (Date rec'd by registrar) (b) Turrington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1947, at 1:34 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8 1947, to 12-19 1947, and that I last saw h.e alive on 12-19 1947.

Immediate cause of death: Congestive failure — Duration

Due to: Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: [signature] M. D.
Address Union Mem. Hosp. Date signed 12-22-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

658197 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3905 DOLFIELD AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3905 DOLFIELD AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** BEN G. BERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife BLANCHE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace BALTO. MD
(Town, county, and state)

10. Usual Occupation ADVERTISING BUS.

11. Industry or business

FATHER 12. Name HOX BERMAN

13. Birthplace RUSSIA

MOTHER 14. Maiden Name REBECCA

15. Birthplace RUSSIA

16 (a) Informant WIFE

(b) Address 3905 DOLFIELD AVE

17 (a) BURIAL (b) Date thereof 12-21-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory HERRING RUN

Location PHIL. RD.

18 (a) Funeral director JACK LEWIS INC

(b) Address 2100 EUTAW PL

19 (a) DEC 21 1947 (b)
(Date received by registrar) Registrar

V S 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1946 to Dec 19 1947, and that I last saw him alive on Dec 19 1947.

Immediate cause of death	Duration
Carcinoma of Rectum	1 1/2 yrs
Due to Carcinomatosis generalized	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation June 20 1946

Major findings of operation: Inoperable Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.

Address 9 Cedarcroft Rd Date signed 12/20/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1163 H

658198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2329 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adele Rosenthal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex f | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Gustav

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name not known

13. Birthplace Germany

MOTHER 14. Maiden Name Pauline

15. Birthplace Germany

16 (a) Informant Gert Rosenthal

(b) Address 3926 Oakford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila. & Harrelton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

DEC 21 1947 Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19/47 19 at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/19/47 at 3:00 P.M.
(b) Where did injury occur? 2329 Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Turned on gas burners

23. Signature John L. Davis M.D.
Medical Examiner.
Date signed 12/20/47

G58199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH VIII A

G58199 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument + Rutland
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Quantico Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Tillie Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Simon Schwartz
(b) Address 2615 Quantico Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place

19 (a) DEC 21 1947 (Date rec'd by registrar) (b) Frederick Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1947 to Dec 19 1947 and that I last saw h alive on Dec 19 1947

Immediate cause of death	Duration
Pulmonary Embolism	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Edward Neuhaus M. D.
Address Sinai Date signed

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65820 0.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~65820~~ 46 A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 E Ostend
(c) Hospital or institution:
73
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E Ostend
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Joseph Flynn

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish Am.	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M.

6 (b) Name of husband or wife Rose McCabe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/1884

8. AGE: Years	Months	Days	If less than one day
63	11	12	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business

FATHER	12. Name Patrick Flynn
	13. Birthplace Ireland
MOTHER	14. Maiden Name Bridget Gaughan
	15. Birthplace Ireland

16 (a) Informant Mr John Flynn
(b) Address 13 E Ostend St.
17 (a) Burial (b) Date thereof 12/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Burr National
Location Frederick Ave
18 (a) Funeral director J. J. Fahey Stone
(b) Address 121 S Light St.
19 (a) Dec 23 1947 (b) Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1947, at 5.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1947, to Dec 18 1947
and that I last saw him alive on Dec 18 1947

Immediate cause of death	Duration
Carcinoma of Oesophagus	ago?
Due to	
Duodenal Hypertrophy Pyloric Obstruction	
Other Conditions	
Cachexia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vincent M. Trevona M. D.
Address 1403 S Charles St Date signed 12/19/47

X

658301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

658201 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 Hanover St
(c) Hospital or institution: 43

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Agnes Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Chas O Baker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/21/1882

8. AGE: Years 64 | Months | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name Willard J Fahey

13. Birthplace Balto

MOTHER 14. Maiden Name Agnes Conway

15. Birthplace Baltimore Md

16 (a) Informant Mrs Mendel

(b) Address 1626 Hanover St

17 (a) Burial (b) Date thereof 12/22/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Ritchie Highway

18 (a) Funeral director J. Fahey Sons

(b) Address 131 E Light St.

DEC 23 1947

19 (a) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1947, at 9P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16/47 to 12/18/47, and that I last saw her alive on 12/16/47

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to: arteriosclerosis

Due to:

Other Conditions: Diabetes — 2 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Muller M D M. D.

Address 1211 E Monument St Date signed

94A 12 19/47

658.02

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

658.02 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland MONUMENT & RUTLAND
(b) Street address ~~426 N. CAMDEN ST.~~
(c) Hospital or institution: SINAI HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N. CAMDEN ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY BLUDZUNS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WID.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known ?

8. AGE: Years	Months	Days	If less than one day
60 ?			hr. min.

9. Birthplace LITHUANIA (Town, county, and state)
10. Usual Occupation TAVERN OWNER
11. Industry or business

FATHER
12. Name ? Victor
13. Birthplace Lithuania

MOTHER
14. Maiden Name ?
15. Birthplace Lithuania

16 (a) Informant Vera Bludzuns
(b) Address 426 W. Camden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23 - 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Location 4430 Belair Road

18 (a) Funeral director John J. Grebauskas Jr.
(b) Address 423 Biddle St

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Harrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 18, 1947, at 2.7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC. 16, 1947 to DEC 18, 1947 and that I last saw her alive on DEC. 18, 1947

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Pneumonia	
Cerebrovascular accident	
Due to Diabetes mellitus.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac M. Cushner, M.D.
Address Sinai Hosp Date signed 12-19-47 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(FS 110360) 658203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 A

658203 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals ?
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 657 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vincent Valinska Or Vincent Valinskas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April ? 1877

8. AGE: Years	Months	Days	If less than one day
70 ?	8		hr. min.

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Matthew Valinska
13. Birthplace Lith.

MOTHER
14. Maiden Name Vera Grinins
15. Birthplace Lith.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec-22-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director John A. Strebliouchas Jr.
(b) Address 423 E. Baltimore St. Baltimore, Md.

19 (a) Dec 23 1947 (b) (Filed by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1947, at 4.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 9, 1947 to Dec. 18 1947, and that I last saw h. im alive on Dec. 18 1947

Immediate cause of death: Tabes dorsalis — Duration: 6 yrs.
Due to:
Due to:
Other Conditions: Parkinsonism — 4 yrs.
Syphilitic Heart Dis. — 6 yrs.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. J. Crosby
Address Balto City Hosp Date signed 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G58204

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1475 Reynolds St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1475 Reynold St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANTHONY ANZUALIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Veronica E. Anguliss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Know ?

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation =

11. Industry or business

FATHER 12. Name ? Anzualis

13. Birthplace Lithuania

MOTHER 14. Maiden Name ?

15. Birthplace Lithuania

16 (a) Informant Anthony Anzualis

(b) Address 1475 Reynolds St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22-47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Location Brooklyn, Md

18 (a) Funeral director John A. Greblunas Jr.

(b) Address 423 S. Paca St.

19 (d) DEC 21 1947 (Date rec'd by registrar) (Written from Williams, Md.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1947, at 1. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1947 to Dec 18 1947. and that I last saw h[illegible] alive on Dec 18 19 47

Immediate cause of death Acute hafalnitis — Duration 2d.

Due to Myocardial failure & pulmonary edema — 2days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Geo. D. Lipsey M. D.

Address 324 Patterson Park Ave. Date signed 12/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

658305 ✓ 658305 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 W. Calhoun St
(c) Hospital or institution: Franklin Sq. Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓ (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Kusterer ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1894

8. AGE: Years	Months	Days	If less than one day
53	11	15	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Heinrich Kusterer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant John Bauer
(b) Address 2552 Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Mem. Woodlawn
Location Baltimore County Md.

18 (a) Funeral director Dill Bros.
(b) Address 3709 Fredrick Ave.

19 (a) Date received (b) Wilmington Williams, M.D. Registrar
DEC 22 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Dec 1947, at 1.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Nov 1947, to 18 Dec 1947, and that I last saw him alive on 12 Dec 1947

Immediate cause of death	Duration
Cerebral hemorrhage	
Bronchopneumonia	
Due to Hypertension C.V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq. Hosp. Date signed 18 Dec 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

658206 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lincoln & Mason

(c) Hospital or institution: MD. GEN. HOSP. 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 HRS

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2022 Edmondson Ave # 23 (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MRS. ESTELLE SADLER

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Albert C. Sadler

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 1, 1888

8. AGE: Years 59 | Months 4 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace: Davis Carlisle (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Joseph Mason

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden Name: Rebecca Jenkins

MOTHER — 15. Birthplace: Baltimore, Md.

16 (a) Informant: Robert W. Sadler

(b) Address: 1012 Ingleside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral

Location: Baltimore, Md.

18 (a) Funeral director: George L. Schwab

(b) Address: 2104 Ft. Frederick Ave.

19 (a) 21 1947 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 20 1947 12:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1947 to 12-20 1947, and that I last saw her alive on 12-19 1947

	Duration
Immediate cause of death: Cardiac Failure	
Due to: Hypertensive Cardio-vascular Disease	
Due to:	
Other Conditions: Terminal Bilateral Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: J. L. Morrow Jr. M. D.

Address: Md. Gen. Hosp. Date signed 12-20-47

VS 150

Transcript 658-07

BALTIMORE CITY HEALTH DEPARTMENT ✓ 658-07
Registered No.

CERTIFICATE OF DEATH 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2013 Annapolis Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 Annapolis Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna L. Imuhl.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm. A. Imuhl.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 1883

8. AGE: Years 64 | Months 10 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Insurance Agent.
11. Industry or business Retired

FATHER
12. Name Heuther
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Edna Imuhl Brun
(b) Address Riverside Drive High Bridge

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto. Md.

18 (a) Funeral director Jennie C. Lyter
(b) Address 1600 W. North Ave.

19 (a) DEC 21 1947 (Date filed by registrar) (b) Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1947, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 17 1947 and that I last saw h[illegible] alive on Dec 16 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 4 days
Due to:
Due to:
Other Conditions: Diabetes Mellitus — 7 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Schultz
Address 821 Annapolis Date signed 12/18/47 (M. D.)

V S 150

9 4A

G58208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

G58208 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 Northway
(c) Hospital or institution: Guilford
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 Northway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Julia H. Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17 1876

8. AGE: Years 70 | Months 1 | Days 2 | If less than one day hr. min. 867

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Edward Martin
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Anne Dentz
15. Birthplace Philadelphia Pa.

16 (a) Informant Miss Lydia C. Martin
(b) Address 216 Northway Guilford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Baltimore Md.

18 (a) Funeral director Jeannie Cook Jeffers
(b) Address 1600 W. North ave.

19 DEC 21 1947 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1947, at 1-10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Dec 19 1947, and that I last saw her alive on Dec 19 1947.

Immediate cause of death: Uraemia — Duration: 2 days

Due to: Carcinoma Breast & pleural carcinomatosis — Duration: past yr.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Bauman and Lord M. D.

Address 2200 Garrison Blvd Date signed 12/20/47

V S 150

Transcription from Williams, M.E.

658209 BC 2-8 1938

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1950

658209 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3305 Hayward Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town).
(d) Street No. 3305 Hayward Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Williams Sitterding Jr

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 17- 1947

8. AGE: Years	Months	Days	If less than one day
	4	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Wm. Sitterding Sr
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Dorothy O. Ross
15. Birthplace West Virginia

16 (a) Informant George Wm Sitterding Sr
(b) Address 3305 Hayward Ave.

17 (a) Burial (b) Date thereof Dec 22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore - Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) (b) Huntington Williams Mortician
(Must be filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18 1947 to 12-[illegible] 1947, and that I last saw h[illegible] alive on 12-18 1947

Immediate cause of death Asphyxiation / Smith
Due to Suffocation
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide acc 27-17
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury
Signature Thos J Abbott M. D.
Address 4509 Liberty Heights Ave Date signed 12-20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G58210 Registered No.

55E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 197 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town College Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125-14 Lax Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Joseph Henry Parent

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	070-16-1031

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ellen Brown Parent
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 22, 1903

8. AGE: Years	Months	Days	If less than one day
44	8	24	....hr. ....min.

9. Birthplace Fall River, Mass.
(Town, county, and state)
10. Usual Occupation Deckhand
11. Industry or business Merchant Seaman

FATHER
12. Name Frederick Parent
13. Birthplace Quebec

MOTHER
14. Maiden Name Emma Moreau
15. Birthplace Quebec

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Dec 22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Stevens Presbyterian
Location Balto Md.
18 (a) Funeral director Ellsworth Armacost
(b) Address 391 Silverton Heights Ave
19 (a) DEC 21 1947 Registered by Wilhelmina Mohr Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1947, at 9:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to Dec. 16 1947, and that I last saw him alive on Dec. 16 1947

Immediate cause of death Lymphosarcoma, generalized (Grant follicular lymphoma type) — Duration MORE THAN 7 YRS

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/19/47

335520 58211 (1588311)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME Lucy Smith Sample

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/29/97

8. AGE: Years	Months	Days	If less than one day
50	3	19	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Grant Smith
13. Birthplace Va

MOTHER
14. Maiden Name Sarah Map
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery or crematory Bethel Church Cem.
Location Eastville (Cape Chas. Va.)

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) 22 1947 (Date rec'd by Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1947, at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1947 to 12/18 1947 and that I last saw her alive on 12/18 1947.

Immediate cause of death: Laennecs Cirrhosis — Duration: 4 mos
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy Laennecs Cirrhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas E. Van Metre M.D.
Address Johns Hopkins Hosp. Date signed 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58212 ✓ G58212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3406 Mohawk Ave
(c) Hospital or institution: 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME EMILY WILCOX LINHARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Ferdinand Linhard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/18/67

8. AGE: Years	Months	Days	If less than one day
80	7		hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Wilcox
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Jane Strible
15. Birthplace Maryland

16 (a) Informant S. R. Mears
(b) Address 805 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Maryland

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N Calvert St.

19 (a) Dec 23 1947 (Date rec'd by registrar) (b) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1947 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Dec 13 1947 and that I last saw h w alive on Nov 13 1947

Immediate cause of death As Stated

	Duration
Due to Pericarditis & Bronchopneumonia	1 mo
Due to Brain Softening	2 mos
Due to Hardening of Arteries	1
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Mears
Address 2136 Kenyon Date signed 12-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G58213
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 Chestnut Hill Ave.
(c) Hospital or institution: 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Chestnut Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA ANNA BEYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~of wife~~ Michael Beyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 16, 1865.

8. AGE: Years	Months	Days	If less than one day
82	8	4	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Joseph Pranke
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Miss Anna E. Beyer
(b) Address 902 Chestnut Hill Ave.

17 (a) Burial (b) Date thereof 12/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~xxxxxxxx~~ New Cathedral Cem.
Location Balto. Md.

18 (a) Funeral director Wm. J TICKNER & SONS INC.
(b) Address North & Pa. Ave. Balto. 17, Md.

19 (a) Dec 21 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1947, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1947, to Dec 20 1947, and that I last saw h. ~~e~~ alive on Dec 15 1947.

Immediate cause of death	Duration
Cardiac Decompensation	2 mos.
Due to Arteriosclerotic Cardiovascular Dis.	10 yrs.
Due to Senility	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel P. Menaker M. D.
Address 1910 N. North Ave Date signed Dec. 21, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

658214 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 Dunkirk Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM R. WEBER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie C. Weber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1886

8. AGE: Years	Months	Days	If less than one day
61	8	17	hr. min.

9. Birthplace Filghmans, Md.
(Town, county, and state)
10. Usual Occupation Accountants
11. Industry or business Patapsco Scrap & Iron Co.

FATHER
12. Name Walter Weber
13. Birthplace Maryland

MOTHER
14. Maiden Name Minnie C. Rowelson
15. Birthplace Maryland

16 (a) Informant Miss Lillian Weber - Daughter
(b) Address 205 Dunkirk Rd.

17 (a) Burial (b) Date thereof 12/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn Cemetery
Location Baltimore County, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Penna. Aves; Balto. Md.

DEC 21 1947
(Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19, 1947, at 9.10 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to Generalized arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-19-47 at 8 a. M.
(b) Where did injury occur? Patapsco Scrap & Iron Co. Fairfield, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell over

23. Signature Earl L. Rigby M.D.
Medical Examiner
Date signed 12-19-47

VS 151

658315 ✓ 658315

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fee correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 Pennsylvania Ave.
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 71 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John C CHARLES Greb JOHN CHARLES GREB

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Cora E. Greb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1876

8. AGE: Years	Months	Days	If less than one day
71	6	15	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Confectioner

11. Industry or business Self

FATHER
12. Name August Greb
13. Birthplace Germany

MOTHER
14. Maiden Name Margarat Meidner
15. Birthplace Germany

16 (a) Informant Mrs. Cora E. Greb
(b) Address 1501 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/47 (month) (day) (year)
(c) Cemetery Lorraine Pk Mausoleum
Location Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Sons Inc.
(b) Address North & Pa. Balto. Md. 17

19 (a) DEC 23 1947 (Date received by registrar) (b) Huntington Station, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1947, at 6 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1947, to Dec 19 1947, and that I last saw h alive on 19

Immediate cause of death	Duration
Pulmonary edema	3 days
Due to Pernicious Anaemia	6 mos.
Due to Cirrhosis of liver	?
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. S. French M. D.
Address 2379 Arunah Ave Date signed 12/24/47

G58216

BALTIMORE CITY HEALTH DEPARTMENT ✓ G58216
Registered No.

CERTIFICATE OF DEATH 131a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5717 WINNER AVE
(c) Hospital or institution: 27-19
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 5717 WINNER AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDNA ESTELLA LOUISE PRAGER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) OCT 17, 1888

8. AGE: Years 59 | Months 2 | Days 3 | If less than one day ___ hr. ___ min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business —

FATHER
12. Name CHARLES A. PRAGER
13. Birthplace BALTO, MD.

MOTHER
14. Maiden Name MARY C. SCHAFF
15. Birthplace BALTO. MD.

16 (a) Informant MRS LOUISE P. EISENHART - SISTER
(b) Address 5717 WINNER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/23/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ WESTERN CEM.
Location BALTO., MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address NORTH & FA. AVES., BALTO, MD

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

DEC 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 20 1947, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 17 1947 to DEC 20 1947 and that I last saw he alive on DEC 20 1947.

Immediate cause of death	Duration
Chronic Myocarditis	1 yr 5
Due to	
Due to Chr. Interstitial nephritis	1 yr 5
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Brown M. D.
Address 16630 York Rd Date signed 12/21/47

X

658217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 658217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey Street 12-5
(c) Hospital or institution:
Good Samartian Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Guilford Street (If rural give location)
(e) Citizen of foreign country? Ireland (Yes or No)
If yes, name country

3 (a) FULL NAME SAHRA MANNING

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Unemployed

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Marie A. Carlton
(b) Address 27 N. Carey Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23, 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St, Paul Street

19 DEC 22 1947 (Date received by Registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1947 at 5 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1947 to Dec 19 1947. and that I last saw h alive on Dec 19 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Arterio Sclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Glassman M. D.
Address 753 W. Lafayette Date signed 12/22/47

X

58218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓-058218 Registered No. 1370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4425 Belmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H Treadwell

3 (b) If veteran, name war —
3 (c) Social Security Account No. 214-03-1496

4 Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ethelyn
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 24. 1876
8. AGE: Years 70 Months 5 Days 29 If less than one day hr. min.
9. Birthplace Baltimore Co Md (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Wilson H Treadwell
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Sarah A Clayton
15. Birthplace Baltimore Co Md

16 (a) Informant H. E. Treadwell
(b) Address 605 Stonleigh Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Md
Location Baltimore Md
18 (a) Funeral director Wilson & Son
(b) Address 1217 E Oliver St
19 DEC 22 1947 (Date died) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1947, at 6 15 M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Dec 20 1947 and that I last saw h. I M alive on Dec 19 1947

Immediate cause of death	Duration
Hypertrophied Prostate	
Uremia	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph Fowler M.D.
Address 441 E Edmondson Ave Date signed 12/20/47

X

658219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 658219

AB-78215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 S. Sharpe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Muir

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ~~ years

7. Birth date of deceased (mo., day, yr.) Dec. 22-1867

8. AGE: Years	Months	Days	If less than one day
79 yrs	11	29	hr. min.

9. Birthplace Maryland (Town, county, and state) Clark
10. Usual Occupation Old Age Pension
11. Industry or business

FATHER
12. Name Henry Clay Muir
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Wilson
15. Birthplace Pennsylvania

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 DEC 22 1947 (Date received by registrar) (By) Registrar

V S 15C

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21- 19 47 at 3.22A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25- 19 42 to 12-21 19 47 and that I last saw him alive on 12-21- 19 47

Immediate cause of death Carcinoma of ascending Colon & Perforation of Caecum & Generalized Peritonitis — Duration

Due to

Due to

Other Conditions Carcinomatosis. HCVD.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto City Hosps. Date signed 12-24-47

058220

BALTIMORE CITY HEALTH DEPARTMENT

AB-115663

CERTIFICATE OF DEATH 47a

Registered No. 058220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals GG
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16days
(e) Length of stay in Baltimore (yrs., mos., or days) 16days?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Harford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert J. Holter

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: M — 5. Color or race: W — 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) ?-?-? 1885

8. AGE: Years 62 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace ? Balto. Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name Louis Holter
13. Birthplace Penna

MOTHER — 14. Maiden Name Mary Birmingham
15. Birthplace Ireland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul st.

19 (a) DEC 22 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17- 1947, at 8.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1- 1947 to 12-17 1947, and that I last saw h alive on 12-14 1947

	Duration
Immediate cause of death Respiratory failure	Hrs
Due to metastases to rectum & lungs	2 mos
Due to CA of rectum	18 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/16/47
Major findings of operation: CA of rectum
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt City Hosps Date signed 12/21/47

X

C38221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

C38221 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1003 Poplar Grove St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Gordshell Ramsey

3 (b) If veteran, name war: W I
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: George E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1863

8. AGE: Years 84 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant John L Young
(b) Address 700 Linwood St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery or crematory Londa Park
Location Baltimore Md

18 (a) Funeral director Williams & Dye
(b) Address 1217 E Fort Ave

19 DEC 22 1947 (Date filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1937 to Dec 19 1947, and that I last saw h er alive on Dec 18 1947

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D Cleon Laughlin M.D.
Address 400 N. Payson St. Date signed 12/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

658222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 658222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2720 Maryland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2720 Maryland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. HUTCHINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widowed

6 (b) Name of husband ~~or wife~~ Tothill C. Hutchins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14th 1861

8. AGE: Years	Months	Days	If less than one day
86	3	7	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name William Black
13. Birthplace Unknown

MOTHER
14. Maiden Name Lida Getrust
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mildred H. Saville
(b) Address 2720 Maryland Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 DEC 22 1947 (Date rec'd by registrar) (b) ~~Inactive~~ Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/47 19 , at 9:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Arteriosclerotic Cardiovascular Disease
(b)
Due to
(c)
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. (Medical Examiner.)
Date signed 12/21/47

658223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

658223 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Harwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth T. Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Peter J. Schwartz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12th 1882

8. AGE: Years 65 | Months 11 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name (Unknown) Trautle

13. Birthplace Germany

MOTHER 14. Maiden Name Johanna (Unknown)

15. Birthplace Germany

16 (a) Informant Mrs Mary E. Ewashen

(b) Address 604 Harwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)

(c) Cemetery ~~accessory~~ Moreland Park

Location Parkville Md.

18 (a) Funeral director Williams Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) DEC 22 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/47 19 , at 9 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 12/21/47

VS 191

X

658224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 658224

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward & Green Sts
(c) Hospital or institution: -
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Princess Anne Md
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Hampton & Md. Penitentiary (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joe Jones
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race colored
6 (a) Single, married, widowed, or divorced. not known
6 (b) Name of husband or wife not known
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) not known
8. AGE: Years 59 Months ? Days ? If less than one day ____ hr. ____ min.
9. Birthplace unknown (Town, county, and state)
10. Usual Occupation unknown
11. Industry or business
FATHER 12. Name unknown
13. Birthplace
MOTHER 14. Maiden Name unknown
15. Birthplace
16 (a) Informant —
(b) Address
17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 10 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) DEC 22 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1947, at 8 30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1947 to Dec 6 1947, and that I last saw him alive on Dec 6 1947.

Immediate cause of death	Duration
insanition	
Due to Carcinoma of lung	
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: not done
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. C. Duvall Jr. M.D.
Address University Hosp. Date signed Dec 9

VS 150

658225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 658225

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp; Baltimore, Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Adelaide Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1878

8. AGE: Years 69 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual Occupation Broker

11. Industry or business

FATHER
12. Name Jerome Hill
13. Birthplace Tennessee

MOTHER
14. Maiden Name Callie Frentress
15. Birthplace Tennessee

16 (a) Informant Mrs. Adelaide Hill
(b) Address Owings Mills, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 22 19 47 (month) (day) (year)
(c) Cemetery or crematory Belle Fountaine
Location St Louis Mo.

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Eutaw Sts

19 (DEC 22 1947) (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21 1947 at 10:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1947 to 12-21 1947 and that I last saw h.i.m. alive on 12-21 1947

Immediate cause of death: Coronary occlusion Cerebral Thrombosis — Duration 8 days
Due to Arteriosclerotic Heart disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Reg Funeral monthly, see [illegible]

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M. D.
Address Union Memorial Hospital Date signed Dec 21, 19[illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~358226~~ 1958226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

Registered No. 1958226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~7~~ 2
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BETTY VITAK

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Jacob Vitak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1891

8. AGE: Years	Months	Days	If less than one day
56	3	10	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Bernat
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Jacob Vitak - husband
(b) Address 2513 E. Madison St.

17 (a) Burial (b) Date thereof 12/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison St.

19 DEC 22 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1947, at 12:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947, to Dec. 18 1947, and that I last saw h[illegible] alive on Dec. 18 1947.

Immediate cause of death	Duration
Acute cardiac decompensation	1 day
Due to arteriosclerosis hypertension	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Klein M.D.
Address 2623 E. Mon. St. Date signed 12/29/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

658227 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26 E Wheeling St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 E. Wheeling St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Estella Elizabeth Curle

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Reuben Curle

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Dec. 17 1876

8. AGE: Years 71 | Months - | Days | If less than one day ... hr. ... min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph D. Hardy
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Priscilla Weller
15. Birthplace Balto. Md.

16 (a) Informant Reuben Curle
(b) Address 26 E Wheeling St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Road

18 (a) Funeral director Wm J. Mullen Sons
(b) Address 2437 E Oliver St

19 (a) DEC 22 1947 (Date rec'd by registrar) (b) Interment for Hillsboro, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1947, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1943 to Dec. 18, 1947, and that I last saw ... alive on Dec. 18, 1947.

Immediate cause of death: Hypertension Cardio vascular renal disease — Duration

Due to

Due to

Other Conditions Hemiplegia - left. Cerebral Infarct.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. P. Friedman, M. D.

Address 1319 Light St. Date signed 12/19/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 058328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Franklintown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olga Kolb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Herman

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Jan. 30- 1905

8. AGE: Years 42 | Months 10 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Godfrey Luthy
13. Birthplace Switzerland

MOTHER
14. Maiden Name Nannette Grutter
15. Birthplace Switzerland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Johns
Location Elliott Station

18 (a) Funeral director J. L. Smithgall Jr.
(b) Address 518 N. Franklintown Rd

19 (a) DEC 22 1947 (Received by registrar) (b)

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21- 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1944 to 12-21 1947, and that I last saw her alive on 12-21- 1947

Immediate cause of death Pulmonary Tbc

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert P. Farber M. D.

Address Balto City Hosps Date signed 12-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 058229

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2600 Huron Street
(c) Hospital or institution: 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Huron St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES T. PARKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1870

8. AGE: Years	Months	Days	If less than one day
77	4	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name John F. Parker
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie E. Owings
15. Birthplace Md.

16 (a) Informant Mr. William Parker
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hensley
(b) Address 578 W. Biddle St.

19 (a) DEC 22 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Dec. 19 1947, at 6:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29/1947 to 12/19/1947 and that I last saw him alive on 12/19/1947

Immediate cause of death	Duration
Chronic Nephritis	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 456 W. Biddle St. Date signed 12/20/47

C58230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1469

Registered No. C58230

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 Sanford Place
(c) Hospital or institution: —
14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Sanford Place
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William N. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	colored	Married

6 (b) Name of husband or wife Clara Smith

6 (c) If alive, give age , years

7. Birth date of deceased (mo., day, yr.) May 20 1877

8. AGE: Years	Months	Days	If less than one day
70	6	29	hr. min.

9. Birthplace Baltimore (Town or county) Md.

10. Usual Occupation Porter

11. Industry or business Clothing factory

FATHER
12. Name John Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Thomas
15. Birthplace Md.

16 (a) Informant Clara Smith wife
(b) Address 504 Sanford Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director John M. Johnson
(b) Address 1300 Druid Hill Ave.

19 (a) DEC 22 1947 (Date rec'd by registrar) (b) Hunting Town Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19th 1947 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1947 to 12.19 1947 and that I last saw him alive on 12-18 1947

Immediate cause of death

	Duration
Carcinoma of Pancreas	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M.D.

Address 500 E. Madison St Date signed 12-19-47

Rayner Browne X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

358231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No. 358231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 36 S. Fremont Ave
(c) Hospital or institution: ~ 183

(d) Length of stay in hospital or inst. (yrs., mos., or days) ~
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) Country
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 36 S Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Monroe

3 (b) If veteran, name war ~ | 3 (c) Social Security Account No. ~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widowed

6 (b) Name of husband or wife Lola Julia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 1877

8. AGE: Years	Months	Days	If less than one day
70	1	26	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Self

FATHER 12. Name Adam Monroe
13. Birthplace Lithuania

MOTHER 14. Maiden Name Julia Yuskevich
15. Birthplace Lithuania

16 (a) Informant Mrs Nellie M. Monroe
(b) Address 36 S. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location 4439 Belair Road

18 (a) Funeral director John Conway Son
(b) Address 907 N Gilmor St

19 (a) DEC 29 1947 Huntington Williams M.D. (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1947 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1947 to 26 Dec 1947 and that I last saw him alive on 26 Dec 1947

Immediate cause of death Uremia — Duration 3 days

Due to Cardio Renal disease — Duration years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Townsend
Address 910 W. Lombard St Date signed 28 Dec 1947

VS 150

Yuskevich

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

658232
446192

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. 658232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Colvin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary Thomas
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 60 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Berl Thomas
13. Birthplace Va

MOTHER
14. Maiden Name Paulina
15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23rd / 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calv. Cem.
Location Brooklyn Md. 9

18 (a) Funeral director Elmer O Wilson
(b) Address 1000 Brentford Ave Baltimore, Md

19 (a) DEC 22 1947 (b) Baltimore, Md
(Date received by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 20 1947 at 4 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19-1947 to 12-21-1947 and that I last saw him alive on 12-20-1947.

Immediate cause of death	Duration
(a) Intraventricular Hemorrhage of the Brain	
Due to Essential Hypertension	
Due to	
Other Conditions Ventricular right ventricle of the heart.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herman M. Millinkoff
Address Johns Hopkins Hosp. Date signed 12/23/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 058233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2620 Pierpont Str.
(c) Hospital or institution: 253
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2620 Pierpont Str.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Charles William Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Coloured

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Maggie Boone deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb-11-1874

8. AGE: Years 73 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Calvert County Md. (Town, county and state)

10. Usual Occupation Bricklayer (retired)

11. Industry or business

FATHER
12. Name Charles W. Boone Sr
13. Birthplace Calvert County

MOTHER
14. Maiden Name unknown
15. Birthplace Anndel Co Md

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22nd 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Mt Winans

18 (a) Funeral director Elroy O Welsh
(b) Address 1900 Brantley Ave Huntington Williamsport

DEC 22 1947
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December-18-1947 at 6.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March-19-1947 to death 19, and that I last saw h[illegible] alive on December-13-1947

Immediate cause of death	Duration
Heart failure	
Due to Coronar sclerosis	
Due to generalized Athero-sclerosis	
Other Conditions Paralysis after cerebral hemorrhage.	9 mos.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter L. Sonnenfeldt M.D.
Address 2708 Hollins Ferry Rd Date signed 12/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

58234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 58234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 Ruxton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Ruxton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Greenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Ruben Caplan
(b) Address 3004 Troga Parkway

17 (a) Burial (b) Date thereof 12-22-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory ROSEDALE
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) DEC 22 1947 (b) [illegible]
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-1947, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Dec 22 1947, and that I last saw her alive on Dec 22 1947.

Immediate cause of death: Acute cardiac failure — Duration

Due to: Myocarditis

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. E. Neale M.D.

Address 3314 W. Mulberry Date signed 12/24/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C58235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 East Landale St
(c) Hospital or institution: 23-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give county)
(d) Street No. 22 East Landall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Collector

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Krowe
13. Birthplace Russia

MOTHER
14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant Harry Ackerler

(b) Address 728 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 420 Eastern Place

19 (a) DEC 22 1947 (Date received by Registrar) (b) Number of certificate (if registered) Permit for Williamsport

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-1947, at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Dec 22 1947; and that I last saw h alive on Dec 22 1947.

Immediate cause of death	Duration
Carcinoma Transverse Colon & Metastasis to Lungs	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 1946

Major findings of operation: Carcinoma Transverse Colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Ackman M.D.

Address 1921 W Lafayette Date signed 12/22/47 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. C58236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3826 Pall Mall Road
(c) Hospital or institution: 15.17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3826 PallMall Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Engel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace London
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Harris Caro
13. Birthplace Germany

MOTHER
14. Maiden Name Leah Weiss
15. Birthplace Germany

16 (a) Informant Mrs Leah Kahan
(b) Address 3826 PallMall Road

17 (a) Burial (b) Date thereof Dec, 22, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cem
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Filed (b) Registrar Dorothy Williams, M.D.
(Date filed by registrar) Registrar

V S 150

MEDICAL CERTIFICATION 9.40

20. DATE OF DEATH December 20 1947, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Dec 20 1947, and that I last saw h-r alive on Dec 20 1947.

Immediate cause of death	Duration
Coronary Occlusion	1/2 hr
Due to	
Due to	
Other Conditions Diabetes	Yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Date signed M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered 658237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 S. Washington St
(c) Hospital or institution: Home 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 S. Washington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anthony Frank Derencz

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-4696

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Genevieve
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 4th, 1885?

8. AGE: Years	Months	Days	If less than one day
62 ?	5	16	hr. min.

9. Birthplace Makowczyzna, Poland. (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business I.L.A. Local 829

FATHER
12. Name Adam Derencz
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Kalinowski
15. Birthplace Poland.

16 (a) Informant Mrs. Genevieve Derencz (Wife)
(b) Address 514 S. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-47 (month) (day) (year)
(c) Cemetery ~~Xxxxxxxx~~ St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (c) DEC 23 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20th 1947, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1947, to Dec. 20 1947, and that I last saw h— alive on Dec. 26 1947

Immediate cause of death: Myocardial Insufficiency — Duration 6 days,
Due to: Cardiac Asthma — 1 yr,
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John V. Fitzpatrick M.D.
Address 1802 Eastern Ave Date signed 12-24-47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

158238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 158238

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 843 Edmondson Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME STERLING R. HOLSEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-2116

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ethel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 9, 1904

8. AGE: Years	Months	Days	If less than one day
43	1	10	hr. min.

9. Birthplace Montgomery Co. Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Henry Holsey
13. Birthplace Montgomery Co. Maryland,

MOTHER 14. Maiden Name Harriett Bowie
15. Birthplace Montgomery Co. Maryland.

16 (a) Informant Ethel Holsey
(b) Address 843 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23, 1947 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Damascus, Maryland.

18 (a) Funeral director Mrs. George H. Holland.
(b) Address 1631 Druid Hill Ave.

19 (a) DEC 22 1947 (Date rec'd by registrar) (b) Transcription from Williams, M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19, 1947, at 2.15p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Syphilitic Aortitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(c) Date of injury 1947 at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 12-20-47

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658239

JL - 116010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

658239

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2477 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Edward Bryant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1880

8. AGE: Years 67 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name David Bryant
13. Birthplace N. C.

MOTHER
14. Maiden Name Harriet Jones
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Md.

18 (a) Funeral director Geo. H. Holland
(b) Address 605 Druid Hill Ave.

19 (a) DEC 22 1947 (b)
(Filed by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1947, at 8.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 1947 to Dec. 20 1947, and that I last saw him alive on Dec. 20 1947.

Immediate cause of death Congestive H. Failure. — Duration

Due to Arteriosclerotic + HCVD

Due to

Other Conditions Bilat. Hydrothorax Anasarca.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: Dr. alone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.

Address Balto City Hosps Date signed 12-20-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

658240 Kershaw CERTIFICATE OF DEATH 1947

Registered No. 658240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1517 Race St.
(c) Hospital or institution: 23-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Race St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma E. Kershaw

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Wid.

6 (b) Name of husband or wife Wm. J. Kershaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/9/1914

8. AGE: Years 33 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Wm. Opfle
13. Birthplace Md.

MOTHER 14. Maiden Name Catherine ?
15. Birthplace Md

16 (a) Informant Family
(b) Address 517 Race Street

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director James L. McCauley
(b) Address 39 E. Fort Ave.

DEC 22 1947 (Date rec'd by registrar) (b) Huntington Wilkins Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1947, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1947, to Dec 19 1947, and that I last saw her alive on Dec 19 1947.

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease	2
Due to Obesity	
Due to Sporadic Lymphocytosis	33 yr. 1 day
Other conditions Cardiac Asthma (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter Kohn M.D.
Address 102 E Fort Ave Date signed 12/20/47

058241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 058241

HARKUM

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and 33rd St
(c) Hospital or institution: Union Memorial Hospital 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 East Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Arthur Garfield Harkum

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) Sept. 1883
8. AGE: Years 64 | Months 3 | Days ? | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none 3 Unemployed
11. Industry or business none

FATHER
12. Name James Harkum
13. Birthplace Virginia

MOTHER
14. Maiden Name Alice Sinclair
15. Birthplace New York

16 (a) Informant Family
(b) Address 123 East Fort Ave, Balto
17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-23-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn Md
18 (a) Funeral director James F. McCauley
(b) Address 320 E. Fort Ave.
19 (a) DEC 22 1947 (Date rec'd by registrar) (b) Huntington Hollins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19-47 19 , at M
21. I certify that death occurred on the date above stated; that I attended deceased from 12-13-47 19 to 12-19-47 19, and that I last saw him alive on 12-19-47 19

Immediate cause of death	Duration
ventricular failure	
Due to myocardial infarction	
Due to coronary occlusion	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James W. C. Fennessy M. D.
Address Union Memorial Hosp. Date signed 12-19-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

No. 058242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 058242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 84
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 N Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John A. Snyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11-1887

8. AGE: Years 60 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John A Chentles
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Shuck
15. Birthplace Germany

16 (a) Informant Mrs John A Snyder
(b) Address 1218 N Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director Wm J Hemm Son
(b) Address 3001 Kentucky Ave

19 (a) DEC 22 1947 (Date received by Registrar) (b) Burington Wm Hemm Son Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1947, at 11 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1947 to 12/19 1947, and that I last saw h Ex alive on 12/15 1947.

Immediate cause of death: acute myocard. infarct — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: acute myoc infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman M Mann

Address Sinai Hosp Date signed 12/19/47 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 058243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 N Bond St
(c) Hospital or institution: 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-3426

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 1897

8. AGE: Years 50 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Norfolk Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Agnes Johnson
(b) Address 1016 N. Bond St

17 (a) Burial (b) Date thereof Dec 24 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. County

18 (a) Funeral director Mrs. Robt A. Elliott Jr
(b) Address 1287 N. Caroline St

19 (a) DEC 22 1947 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1947, at 11:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1947, to Dec. 20 1947, and that I last saw him alive on Dec. 20 1947.

	Duration
Immediate cause of death: Ventricular fibrillation	3 days
Due to: Congestive Heart Failure	1 month
Due to: Hypertension	about 1 yr.
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R W McDaniel M. D.
Address 817 N. Caroline Date signed 12-22-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

658234

Registered No. 1.21a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4701 No. Charles Sts.
(c) Hospital or institution: 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 No. Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sister Mary Rita Prentiple

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 1858

8. AGE: Years	Months	Days	If less than one day
89	7	6 20	hr. min.

9. Birthplace New York City N.Y.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Joseph Prentiple
13. Birthplace Manchester, England

MOTHER
14. Maiden Name Mary Craig
15. Birthplace Manchester England

16 (a) Informant Sr. M. Peter Xavier
(b) Address 4701 No. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23/47 (month) (day) (year)
(c) Cemetery or crematory Mount Dam
Location Charles St

18 (a) Funeral director Geo M. Fairbourn
(b) Address 811 W Lafayette Ave

19 (a) DEC 22 1947 (b) Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21st 1947, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1947 to Dec 20 1947 and that I last saw h[illegible] alive on Dec 20 1947.

Immediate cause of death	Duration
a acute Dilatation	1 wk.
Due to Bronchopneumonia	many
Due to Chr. Hypocardisty	years
b adv. art. Sclerosis	
Due to Chr. nephritis c	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis L. Bagli
Address 1775 N. Calvert St. Date signed 12/22/47

VS 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658245

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 Joppa Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RICHARD ~~COOPER~~ Ralph Cooper

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Ida Eva Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1881

8. AGE: Years 66 | Months 6 | Days — | If less than one day hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Foreman

11. Industry or business: Black & Decker Mfg. Co.

FATHER — 12. Name: Capt. Henry H. Cooper
13. Birthplace: Maryland

MOTHER — 14. Maiden Name: Susan B. Crockett
15. Birthplace: Maryland

16 (a) Informant: Ida E. Cooper
(b) Address: 828 E. Joppa Rd. Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 23, 1947 (month) (day) (year)
(c) Cemetery or crematory: Trinity Cemetery
Location: Long Green, Balto. Co., Md.

18 (a) Funeral director: John Burns' Sons
(b) Address: Towson, Md.

DEC 22 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1947, at 4 a.m. 55 M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Fracture of Skull c intra-cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-15-47 at 3 P. M. Balto. Co.
(b) Where did injury occur? 800 block Joppa Road. Towson.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian-struck by auto

23. Signature: [signature] M.D. Medical Examiner
Date signed 12-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

658246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58C

658246 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1553 Boyle Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Capercoon

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 217-12-0454

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Hilda Capercoon
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 4-1922
8. AGE: Years 25 | Months 6 | Days 17 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Upholsterer.
11. Industry or business

FATHER
12. Name Geo. Capercoon
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Caskey
15. Birthplace Maryland

16 (a) Informant Hilda Capercoon
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location C. I. B.
18 (a) Funeral director C. Howard Evans
(b) Address 1410 E. Baltimore St.
19 (a) DEC 23 1947 Registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/47, 1947, at 11 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1947, to 12/21 1947, and that I last saw him alive on 12/21/ 1947.

Immediate cause of death	Duration
Myocardial failure	
Due to Rheumatic fever	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph D Schrock M. D.
Address Franklin Sq. Hospital Date signed 12-24-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

658247 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 N. Frankland St
(c) Hospital or institution: 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 49 N. Pine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene P. Phileon

3 (b) If veteran, name war: World War #1.
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1893

8. AGE: Years 54 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Kansas S. C. (town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Ernest Phileon
(b) Address 421 N. Pine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore, Maryland

18 (a) Funeral director William H. Jackson
(b) Address 916 Penna. Ave.

DEC 22 1947 (b) (Date rec'd by registrar) Registrar

VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20. 1947, at 9:50 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1947 to Dec 20 1947 and that I last saw him alive on Dec 20 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 hr

Due to: Hypertension — 1 yr

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address 757 Bway Date signed 12-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658248

B-116001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658248

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 49 40 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5min.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 113 Welcome Alley (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18-1947

8. AGE: Years	Months	Days	If less than one day
			hr. 5 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name ?

13. Birthplace ?

MOTHER

14. Maiden Name Dorothy Taylor

15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 12-19-47 (month) (day) (year)

(c) Cemetery or crematory B. C. H. Crematory

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 DEC 22 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Dec. 18 19 47, at 7.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18- 1947, to 12-18 1947, and that I last saw h. 18 alive on 12-18 19 47.

Immediate cause of death asphyxia — Duration

Due to atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: atelectasis of lungs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J. Fetter M. D.

Address Baltimore City Hospitals Date signed 12-19-47

V S 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

158249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 C

Registered No. 158249

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2809 Garrison Blvd.
(c) Hospital or institution: Garrison Nursing Home 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Greenmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARA SANDERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Theodore Sanders
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace UNKNOWN. (Town, county, and state)

10. Usual Occupation LORD BALTO. HOTEL.

11. Industry or business

FATHER
12. Name UNKNOWN.
13. Birthplace "

MOTHER
14. Maiden Name UNKNOWN.
15. Birthplace "

16 (a) Informant FATHER MENDELIS
(b) Address PARK AVE & SARATOGA ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Anne Arundle Co.

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) DEC 22 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.* Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1947, at 9:30 A

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6/1947 to 12/21/1947 and that I last saw her alive on 12/21/1947

Immediate cause of death	Duration
Thrombosis Cerebral	48 hrs
Due to Cerebral Sclerosis	4 years
Due to	
Other Conditions Rheumatic Endocarditis 4 yrs.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C J Mendelis M. D.
Address 651 N Bentalou Date signed 12/22/47

83B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G58250 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2909 St. Paul Street
(c) Hospital or institution: 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edith Frances — BECKER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 73 | Months — | Days — | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Frederick Becker
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Braun
15 Birthplace Baltimore Md

16 (a) Informant Mrs Regenia Abeln
(b) Address 525 E 22nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Medford & Son
(b) Address 58 E. 22nd St

19 (a) DEC 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938, to Dec. 21 1947, and that I last saw her alive on Dec. 20 1947.

Immediate cause of death	Duration
Chronic Nephritis	2 yrs.
Uremia	1 wk.
Due to Arteriosclerosis, generalized; renal	
~~Due to~~ arteriosclerosis	
severe; coronary	
~~Other Conditions~~ arteriosclerosis, severe	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robt. B. Wright M. D.
Address Medical Arts Bldg. Date signed 12/21/47.

X

G58251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G58251 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 941 Bennett Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3 (a) FULL NAME Robert Johnson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1905

8. AGE: Years 42 | Months 7 | Days 14 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore MD (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant ?
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Penna Ave & Laurens Lt.

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) ___ (Date rec'd by registrar) (b) ___ Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1947 at 4:42 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1947 to 12/19 1947 and that I last saw h[illegible] alive on 12/19 1947.

Immediate cause of death: Cerebral Hemmorrhage — Duration
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Garner M. D.
Address 514 Division St Date signed 12/22/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 658252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 39 N. Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 39 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Lillian Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Burnett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1. 1913

8. AGE: Years 34 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Jones
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Burnett Green
(b) Address 39 N. Bruce St

17 (a) Burial (b) Date thereof 12-24-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Avon Ave. & Old Frederick Rd

18 (a) Funeral director G. Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1947, at 11:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1947 to Dec 21 1947 and that I last saw h.P.V. alive on Dec. 21 1947.

Immediate cause of death: Pulmonary Tuberculosis — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard Rentlinger M.D.

Address 426 N. John St Date signed 12-24-47

Tuntington Williams M.D. Registrar

130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58253 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 N. Kresson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N. Kresson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH E. RENNER

3 (b) If veteran, name war ------

3 (c) Social Security Account No. 212-09-7031

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret M. Renner
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) June 26 1881

8. AGE: Years	Months	Days	If less than one day
66	5	24	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph E. Renner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Boyle
15. Birthplace Baltimore, Md.

16 (a) Informant Margaret M. Renner
(b) Address 13 N. Kresson St.

17 (a) Burial (b) Date thereof 12-23-47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location 7401 German Hill Rd.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 901 S. Conkling St.

19 (Date received by registrar) Dec 22 1947 Huntington Ave Baltimore, Md. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1947, at 1:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1947, to Dec. 20 1947, and that I last saw him alive on Dec. 20, 1947.

Immediate cause of death	Duration
Congestive Heart Failure	2 days
Due to Coronary Thrombosis	
Hypertensive Disease	7 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael J. Dausch M. D.
Address 1 W. Ostend Ave Date signed 12/20/47

X

G58254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58254 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: Mercy Hospital H
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6137 Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Myers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name
13. Birthplace
MOTHER 14. Maiden Name
15. Birthplace
16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 DEC 22 1947 (Statement by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27/47 19 at 7 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Dairs M.D. Medical Examiner.
Date signed 11/27/47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658255 658255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2218 Annapolis Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimorem Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 Annapolis Rd.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME ANNA E. NOEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or ~~wife~~ Aloysuis B. Noel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1867

8. AGE: Years	Months	Days	If less than one day
about 80	2	12	hr. min.

9. Birthplace Tyrone, Pa.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Hugh Kearns
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Devine
15. Birthplace Ireland

16 (a) Informant Mrs. Evalyn Barnes
(b) Address 2218 Annapolis Rd.

17 (a) Burial (b) Date thereof 12/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Catheral
Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North Ave. & Pa. Aves. Balto., Md.

19 (a) 1947 (b) Registered
(To be filled in by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1947, at 7:34 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1, 1947 to Dec 19, 1947.
and that I last saw him alive on Dec 19 1947.

Immediate cause of death	Duration
Coronary Thrombosis	4 days
Due to	
Due to	
Other Conditions Arteriosclerosis C. V. D.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Schofield
Address 1901 Annapolis Date signed 12/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

G58256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1201 Argonne Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days) Life years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Argonne Dr. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK G. HENNEMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	Yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife Ruth M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1890

8. AGE: Years	Months	Days	If less than one day
57	11	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Sup. Group Ins.
11. Industry or business Metropolitan

FATHER
12. Name John Henneman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizebeth Litz
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ruth Henneman
(b) Address 1201 Argonne Dr. Balto; Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery or ~~Church~~ Holy Redemer
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address Borhh & Pa. Aves., Balto, Md.

19 (a) DEC 22 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1947, at 2.22A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-1-1946 to Dec-21 1947 and that I last saw him alive on Dec-21-1947.

Immediate cause of death	Duration
Carcinoma Prostate	2yrs.
Due Metastasis Spine & Liver	6 mos
Paraplegia	2 mos
Due to Myocardial Insufficiency	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation May 1947 Orchidectomy
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Wm. G. Geyer M.D.
Address 1566 N. Melton Ave. Date signed Dec. 22 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058c57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

058c57 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3919 Maine Ave.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Maine Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM ROSENSTOCK.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Gertrude H. Rosenstock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1882.

8. AGE: Years 65 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Jeweler.

11. Industry or business

FATHER 12. Name Levi Rosenstock,
13. Birthplace Frederick, Md.

MOTHER 14. Maiden Name Julia Schloss,
15. Birthplace ?

16 (a) Informant Mrs. Gertrude Rosenstock,
(b) Address 3919 Maine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12. 23. 47. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.

19 (a) [illegible] (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 at 1947, at 4.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1947, to 12/20 1947; and that I last saw him alive on 12/20 1947.

Immediate cause of death [illegible] Duration ?
Due to General metastasis ?
Due to Carcinoma of bladder ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank Lerman M. D.
Address 4004 Liberty Heights Ave Date signed 12/21/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

G58258 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane,
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4802 Laurel Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James H. Oursler

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Minnie Clarke Oursler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 26, 1866

8. AGE: Years 81 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace: Carroll County, Md. (Town, county, and state)
10. Usual Occupation: Self Employed,
11. Industry or business: Butter & Egg

FATHER
12. Name: John Curtis Oursler,
13. Birthplace: Carroll County, Md.

MOTHER
14. Maiden Name: Elizabeth Brown,
15. Birthplace: Carroll County, Md.

16 (a) Informant: Mrs. Wendell A. Herman,
(b) Address: 4802 Laurel Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral,
Location: Baltimore City,

18 (a) Funeral director: C. Vernon Lemmon
(b) Address: 4611 Park Heights Ave.

19 DEC 22 1947 (b) [illegible] Registrar
(Date filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19, 1947 at 5. PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1946 to 12/19 1947, and that I last saw him alive on 12/19 1947.

	Duration
Immediate cause of death: BRONCHOPNEUMONIA,	3 days
Due to: GENERALIZED ARTERIOSCLEROSIS	10 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Norman R. Keerman M. D.
Address: 3803 Edmondson Ave. Date signed

X

658259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

658259

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1606 N. PULASKI ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 N. PULASKI ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM P.L. KIRWIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife MARGARET KIRWIN
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JUNE 15, 1878

8. AGE: Years	Months	Days	If less than one day
69	11	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Livery Stable

FATHER
12. Name John Kirwin
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine McGraw
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret Kirwin
(b) Address 1606 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. City

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 DEC 22 1947 (Date received by local registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 20 1947, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 19 to DEC 20 1947, and that I last saw h— alive on DEC 20 1947.

Immediate cause of death	Duration
Due to Cerebral Hemorrhage Muscular Atrophy	about 2 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Henry C. Hewitt M.D.
Address 1521 W. Mulberry St. Date signed 12/21/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

658260 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Spaulding Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles T. Jahnigen Jr. (Charles T. Jahnigen, Jr.)

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-2014

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Edith A. Jahnigen,

6 (c) If alive, give age — — years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1906

8. AGE: Years	Months	Days	If less than one day
41	4	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Guard,

11. Industry or business Race Track,

FATHER
12. Name Charles T. Jahnigen, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Meehan,
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Edith A. Jahnigen, Wife
(b) Address 3503 Spaulding Ave.,

17 (a) Burial (b) Date thereof 12/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Baltimore City.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) DEC 00 1947 (b)
(Registered by registrar) Registrar

VS 150

Transcription for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1947, at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1947 to 12/20 1947 and that I last saw him alive on 12/20 1947.

Immediate cause of death Cardiac failure
pneumonia - from Death,
Uremia & Pyelitis -
Due to
as Myeloid Leukemia
Due to

Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [signature] Date signed 12/20/47 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658261 — BALTIMORE CITY HEALTH DEPARTMENT — 658261

CERTIFICATE OF DEATH 157E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Jacksonville (If outside city or town limits, write RURAL and give town)
(d) Street No. 3731 Fairwood Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jenna Ann Jochum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1947

8. AGE: Years | Months: 4 | Days | If less than one day: hr. min.

9. Birthplace: Florida (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Jochum
13. Birthplace Florida

MOTHER
14. Maiden Name Frances Jochum Shelton
15. Birthplace Georgia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 22/47 (month) (day) (year)
(c) Cemetery or crematory Jacksonville Fla
Location

18 (a) Funeral director Veale Funeral Home
(b) Address 2008 Orleans

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 22 1947

Twitty for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 19 47, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 19 47, to Dec 22 19 47, and that I last saw her alive on Dec 22 19 47.

Immediate cause of death: Pulmonary congestion — Duration

Due to: Pulmonary abscess, Tricuspid stenosis

Due to: non functioning rt. ventricle.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E Thoms M. D.
Address John Hopkins Hosp Baltimore Md Date signed 22 Dec 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

058262 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 Eutaw Place
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days & above address
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1370 N. Eutaw St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Solomon Fenkeimer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife Tillie Fenkeimer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2/1865

8. AGE: Years 82 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Samuel Fenkeimer
13. Birthplace Germany

MOTHER
14. Maiden Name Miriam Kerr
15. Birthplace Germany

16 (a) Informant Mrs. Clara Kerman
(b) Address Sinai Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23/47 (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Cemetery
Location Belair & Erdman Aves

18 (a) Funeral director Hyman Rosenbaum
(b) Address 2413 Reisterstown Rd

19 (a) Dec 20 1947 (Date received by registrar) (b) Registrar's No.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1947 at 11:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to Dec. 21, 1947 and that I last saw h[illegible] alive on Dec. 21, 1947

Immediate cause of death: Myocardial Insufficiency — Duration: 1 week
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature [illegible]
Address 2322 Eutaw Place Date signed M. 12 D. 22 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 58263

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution:
Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Faber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Rachel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1 1867

8. AGE Years	Months	Days	If less than one day
80	8	20	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Farm Hand
11. Industry or business

FATHER
12. Name ?
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Steven Faber Son
(b) Address 4102 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gorman Mill Rd.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Motley St.

19 DEC 22 1947 (Date filed by Registrar) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1947, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1946 to December 1947, and that I last saw him alive on Dec. 20 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to Hypertensive Cardio Vascular — Duration 20 yrs

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman R. Klemm M. D.
Address 3813 Edmondson Ave Date signed 12/23/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 68269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 S. Longwood St.
(c) Hospital or institution: 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 S. Longwood St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand Beyer

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Henrietta Beyer
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) February 20, 1858

8. AGE: Years: 89 | Months: 10 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Balto. Transit Co.

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. August Knust
(b) Address 530 S. Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-47 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director: George L. Schwab
(b) Address 2104 Eastern Ave.

19 DEC 23 1947 (Date filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1947, at 2.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947 to Dec 21 1947, and that I last saw h. l. alive on Dec 15 1947.

	Duration
Immediate cause of death: Arteriosclerosis Nephritis	4 Mos.
Due to:	
Due to:	
Other Conditions: Benign prostatic hypertrophy (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. McAllen M. D.
Address 3321 Frederick Ave Date signed 12/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58245 G58285

AB-103616

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

58245 1/31a

Registered No. G58285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 28.2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5319 Wesley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dennis Maher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5- 1884

8. AGE: Years	Months	Days	If less than one day
63	1	17	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jaramiah Maher
13. Birthplace Ireland

MOTHER
14. Maiden Name Ella Dulaney
15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 2174 E Lanvale St

19 DEC 23 1947 (Date rec'd by Registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Dec. 22- 1947, at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9- 1946 to 12-22- 1947 and that I last saw him alive on 12-22- 1947

Immediate cause of death	Duration
Bronchopneumonia	4-5 days.
Due to Organism undet.	
Cardiac insufficiency	
Due to Hypertension Arteriosclerotic Cardiovasc. disease	3 yrs. ?
Other Conditions Emphysema, pulmonary tuberculosis.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 12-24-47

93D

G58266 S-8266 G58266

BALTIMORE CITY HEALTH DEPARTMENT 94a Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th Street
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs 3 mo 11 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mary Sill

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (d) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Howard Sill, deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19 - 1866

8. AGE: Years 81 | Months 10 | Days 2 | If less than one day ___ hr. ___ min.

9. Birthplace Prince George Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edmund Brice
13. Birthplace Prince George Co. Md.

MOTHER
14. Maiden Name Caroline Landsdale
15. Birthplace Prince George Co. Md.

16 (a) Informant Laura Fischer
(b) Address 700 W 40th Street

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/28/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Wilhelm Bros & Co
(b) Address 1217 E Oliver

19 (a) DEC 23 1947 (Date rec'd by Registrar) (b) [illegible] Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1945, to December 21 1947, and that I last saw h[illegible] alive on December 1947.

	Duration
Immediate cause of death: Coronary Occlusion	24 Hours
Due to: Arteriosclerosis (Hardening of)	5 Years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Braxton Hargrove M. D.
Address 214 Medical Arts Bldg Date signed 12/30/47

58267. Howard J. Shelley 58267 BALTIMORE CITY HEALTH DEPARTMENT 58267 CERTIFICATE OF DEATH 94a Registered No. 58267

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2310 W. Lanvale Street
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 W. Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard J. Shelley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna Shelley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1879

8. AGE: Years	Months	Days	If less than one day
68	5	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown Shelley
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Elizabeth Godfrey
15. Birthplace Baltimore, Maryland

16 (a) Informant Bernard Shelley
(b) Address 2836 Westwood Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/23/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1/47 19 to 12/21/47. and that I last saw him alive on 12/21/47

Immediate cause of death: Thrombosis Coronary — Fatal — Duration

Due to Coronary Sclerosis — years

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 65 W Pleasant Date signed 12/22/47

G58268 58268 G58268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Salvador Citizen

3 (a) FULL NAME EVERETT JASPER

3 (b) If veteran, name war: W
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Retha Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Ga (Town, county, and state)
10. Usual Occupation Helper
11. Industry or business Shipping Army

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Frank W Jasper
(b) Address 278 Lombard St Rear

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (mo.) (day) (yr.)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilson & Dorsey
(b) Address 1217 E Pratt St

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Signature of Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1947, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull
Intracranial Hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-21-47 7.15 P. M.
(b) Where did injury occur? Fayette & Pine St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by street car

23. Signature Earl L Rogers M.D. (Medical Examiner)
Date signed 12-22-47

58269 58269 58269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 480

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 263 Bethel Ct. 6-5
(c) Hospital or institution: Baltimore 31, 1947
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 263 Bethel Ct. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah J. Williams

3 (b) If veteran, name war No

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Rev. John Williams

6 (c) If alive, give age 87 6 years

7. Birth date of deceased (mo., day, yr.) Jan. 6 (1872)

8. AGE: Years 71 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Baretown, N.C. Pitt County (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Johnson Austin

13. Birthplace Pitt Co. N.C.

MOTHER 14. Maiden Name Martha Perkins

15. Birthplace Pitt County N.C.

16 (a) Informant Hannah Hardy

(b) Address 263 Bethel Ct.

17 (a) Removal (b) Date thereof 12/23/47 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Greenville N.C.
Location

18 (a) Funeral director Mr. Chas. H. Alexander

(b) Address 1200 Monument St

DEC 23 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1947, at 10:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 18 1947, to Dec. 21 1947, and that I last saw h-er alive on Dec. 19 1947.

	Duration
Immediate cause of death: Pulmonary Embolus	2 hrs.
Due to: Carcinoma of the Uterus	9 mos.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.

Address 807 N. Caroline St. Date signed 12-22-47

VS 8

X

65870 58-226 65870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Harrington apts.
(b) Street address 3908 N. Charles St
(c) Hospital or institution: 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louisa Orick Bugley Bugley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Stockton Bugley

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 14, 1865

8. AGE: Years 82 | Months 5 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation House wife

11. Industry or business Home

FATHER
12. Name Harry Albert Orick
13. Birthplace Baltimore

MOTHER
14. Maiden Name Martha Burnon Lovering
15. Birthplace Baltimore

16 (a) Informant Mrs John Legg Jr.
(b) Address Washington apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23-1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto md

18 (a) Funeral director Henry H. Jenkins Sons Co
(b) Address 1111 Cathedral St

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Huntington Williams, MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1947, at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947, to Dec 22 1947 and that I last saw her alive on Dec 21 1947.

Immediate cause of death: Cerebral hemorrhage Accident — Duration: 3 days

Due to: Hypertension ? arteriosclerosis ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis W. Glenn M. D.
Address 3406 St Paul St Date signed 12/22/47

X

(58271) 58271 58271 (58271)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Boarman AVe
(c) Hospital or institution: 15.13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Boarman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harris Yaffe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Fannie Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 78 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Morris Yaffe
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Reva ?
15. Birthplace Russia

16 (a) Informant Joseph Yaffe
(b) Address 3807 Forrest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 23, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Frantz for Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION 8.30

20. DATE OF DEATH December 22 19 47 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 19 47 to Dec. 21 19 47
and that I last saw h[illegible] alive on Dec 21 19 47

Immediate cause of death: Encephalomalacia (Cardiac) — Duration: 1 da
Due to: Chronic Myocarditis — 2 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Wm J Bayless M.D.
Address 2040 Eutaw Pl Date signed 12/22/47

X

G58272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63B

Registered No. G58272

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Hilton ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn D. Barrett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Chas. E. Barrett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-21-11

8. AGE: Years 36 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Milton Krantz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Glean Lentz
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Glean Wagner
(b) Address 501 Hilton Ave Catonsville

17 (a) Burial (b) Date thereof 12-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn Md

18 (a) Funeral director Geo. L. Beiser Jr
(b) Address 1512 Holliday St

DEC 23 1947 (b) Huntington Williams Md.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19-47 19 , at 1.00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1947 to 12-19 1947 and that I last saw h.e alive on 12-19 1947.

Immediate cause of death	Duration
Shock	
Due to Hemorrhage	
Due to	
Other Conditions Thyrotoxicosis	

(Include pregnancy within 3 months of death)
Date of operation 12-19-47
Major findings of operation: Toxic goiter
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank J. Brady M. D.
Address Md. Gen. Hosp. Date signed 12-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G58273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5311 Morello Road
(c) Hospital or institution:
none 27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5311 Morello Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Morin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Sadie Lee Munday
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) December 25, 1888

8. AGE: Years	Months	Days	If less than one day
58	11	26	hr. min.

9. Birthplace N. Y.
(Town, county, and state)
10. Usual Occupation Foreman, Gas & Electric Co.
11. Industry or business

FATHER
12. Name Joseph Morin
13. Birthplace N. Y.

MOTHER
14. Maiden Name Nellie Fleury
15. Birthplace N. Y.

16 (a) Informant Herbert L. Morin
(b) Address 208 Mallow Hill Ave.

17 (a) Burial (b) Date thereof 12/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) DEC 22 1947 (b) [illegible] for Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 19 47, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1935 to Dec 21 1947 and that I last saw h[illegible] alive on 12/21 1947

Immediate cause of death — Duration

Coronary thrombosis — 3 yr
Due to (Hypertension)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edw Talbott M. D.
Address 2723 St. Paul St. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 6378

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5318 Tilbury Way
(c) Hospital or institution: none

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5318 Tilbury Way
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Rt. Rev. Edward Trail Helfenstein, D. D.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Grace Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1865

8. AGE: Years 82 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace St. Louis, Mo. (Town, county, and state)
10. Usual Occupation clergyman
11. Industry or business

FATHER
12. Name Cyrus G. Helfenstein
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Annie Trail
15. Birthplace Frederick, Md.

16 (a) Informant Mrs. Grace N. Helfenstein
(b) Address 5318 Tilbury Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery ~~crematory~~ Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) DEC 22 1947 (Date rec'd by registrar) (b) [illegible] Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1930, to Dec 22 1942, and that I last saw him alive on Dec 22 1947.

Immediate cause of death: Myocarditis — Duration: Gradual
Due to: Hypertension
Due to: Arterio-Sclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Reedy M.D.
Address 1403 Park Ave. Date signed 12/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(58275)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 122a

Registered No. 58275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town 4106 Roland Ave Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Grace L. Timanus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-19-64

8. AGE: Years 83 | Months 11 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER — 12. Name Hutchins ?
13. Birthplace Md

MOTHER — 14. Maiden Name Caroline Henning
15. Birthplace Md.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville Balto Co. Md

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 DEC 23 1947 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1947 at 7 50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1947 to Dec 21 1947 and that I last saw h.r alive on Dec 21 1947

	Duration
Immediate cause of death: Respiratory failure	
Due to: Pulmonary tuberculosis	30 yr
Due to:	
Other Conditions: Strangulated femoral hernia (Include pregnancy within 3 months of death)	

Date of operation.....
Major findings of operation: Strangulated femoral hernia
of autopsy: pulmonary tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature H. Hamilton M. D.
Address Johns Hopkins Hosp Date signed 12/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

658276

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street 26

(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 12 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 443 Elmino St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME SARAH REBECCA CRATER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 20, 1903

8. AGE: Years 44 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name Hattie Lord

15. Birthplace Pennsylvania

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory I.O.O.F. Catonsville Md.

Location Catonsville, Md.

18 (a) Funeral director John O. Mitchell

(b) Address 1400 Eastern Ave.

19 DEC 23 1947 (Date rec'd by registrar) Registrar for Baltimore City

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1947, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1947 to Dec 22 1947, and that I last saw h[illegible] alive on Dec. 22 1947.

Immediate cause of death Ovarian adenocarcinoma & widespread metastasis.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. M. Carouge M. D.

Address 6226 Everall Ave. Date signed 12-22-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

058247 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3039 Belmont, Ave
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 36 37 Belmont Ave
(If rural give
(e) Citizen of foreign country? (Yes or No)
If yes, name country Belmont Ave

3 (a) FULL NAME Elsie Mae Lemmon

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James Bowie Lemmon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1878

8. AGE: Years 69 | Months | Days 10 | If less than one day hr. min.

9. Birthplace Eldersburg, Md
(Town, county, and state)

10. Usual Occupation Home duties
11. Industry or business

FATHER
12. Name John Emory Barnes
13. Birthplace Carroll, County

MOTHER
14. Maiden Name Mary Jane Habbersett
15. Birthplace Pa.

16 (a) Informant Mrs Winifred Leishear
(b) Address 3039 Belmont, Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23 47 (month) (day) (year)
(c) Cemetery or crematory Harmony
Location Mabon

18 (a) Funeral director John C. Mitchell Sons
(b) Address 1900 Eutaw Place,

19 (a) DEC 23 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1947, to Dec 20 1947, and that I last saw h alive on 19

Immediate cause of death: Acute cardiac dilatation — Duration: 2 days
Due to: Chronic myocarditis — yrs.
Due to: Hypertension.
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A Cole's M. D.
Address 4 N. Fulton Date signed

VS 150

4 N. Fulton ave, X

G58278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G58278
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 S Sharp
(c) Hospital or institution: 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 S. Sharp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Clay

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Charles Clay

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882.

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Simon Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Mollie Burkett
15. Birthplace Md

16 (a) Informant Viola Langford
(b) Address 1010 S. Sharp St

17 (a) Burial (b) Date thereof Dec 26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Stayes
(b) Address 142 W. Hill St

DEC 29 1947
(Date received by registrar)

V S-150 A-14

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1947 at 6 am M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1947 to 12-22 1947, and that I last saw h. alive on 12-22 1947.

Immediate cause of death	Duration
Myocardial Degeneration	5 Mos
Due to	
Due to	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Blackistone M. D.
Address 543 Penna Ave Date signed 12-29-47

X

G58279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

✓ G58279 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 N. Amity St
(c) Hospital or institution: 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Amity St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev. GENERAL H. TILGHMAN

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mable
6 (c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) 7/10/1893
8. AGE: Years 54 | Months 5 | Days 9 | If less than one day hr. min.
9. Birthplace Kinston N.C. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Frank Tilghman
13. Birthplace N.C.

MOTHER
14. Maiden Name Susan
15. Birthplace N.C.

16 (a) Informant Mable Tilghman (Wife)
(b) Address 115 N. Amity St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.
18 (a) Funeral director Charles S. Cooper
(b) Address 510-12 N. Carrollton Ave
19 DEC 23 1947 (Filed by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19/47 19 , at 9:40 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 19 44 to Dec. 19 19 47 and that I last saw him alive on 12-19- 1947.

	Duration
Immediate cause of death: Cardiac Decompensation	
Due to: Pulmonary T.B.	3 yrs
Due to: Hemorrhage	same day
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Huntington Williams M. D.
Address 2340 Madison Ave Date signed 12-22-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658280 ✓ 658280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 828 China St
(c) Hospital or institution: 22 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 China Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Amelia Ann Rayner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel Carroll
13. Birthplace Md

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Md

16 (a) Informant Myrtle Porter
(b) Address 828 China St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery St.

DEC 23 1947 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1947, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1947, to Dec 20 1947, and that I last saw h alive on Dec 23 1947.

Immediate cause of death	Duration
Cardio-Vascular disease	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watts

Address 1515 Hemp Date signed 12-24-47 M. D.

X

658281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ 658281 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie E. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife Minnie Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 27, 1889

8. AGE: Years	Months	Days	If less than one day
57 58	11	25	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Mattie Brown
15. Birthplace Virginia

16 (a) Informant Bernice Boulware
(b) Address 1109 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24 1947 (month) (day) (year)
(c) Cemetery or crematory Balts. National
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 DEC 23 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1947 at 2 30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Spilsbury M.D. (Medical Examiner.)
Date signed 12/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G58282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G58282

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 S. Penn St
(c) Hospital or institution: 4-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 S. Penn St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie Merriot

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife: Frank Merriot
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1895

8. AGE: Years	Months	Days	If less than one day
52	6		hr. min.

9. Birthplace Wilmington N.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name Edward Mears
13. Birthplace Wilmington N.C.
14. Maiden Name Kendall Smith
15. Birthplace N.C.

16 (a) Informant Edward Merriot
(b) Address 2201 Amity St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mr. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 DEC 23 1947 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 1947 at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17- 1947 to 12-20 1947 and that I last saw h[illegible] alive on 12-20 1947

Immediate cause of death

	Duration
Due to: Cerebral Apoplexy	3
Due to:	hrs
Other Conditions:	7

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B Valeh
Address 1 W 22 Penn Date signed 12/22/47 M.D.

VS 190

58283 ✓ 58283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 N. Harford Ave.
(c) Hospital or institution: 10-
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Harford Ave.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME LUCAS CAMPBELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1896

8. AGE: Years	Months	Days	If less than one day
51 smt	3	7	..... hr. ..... min.

9. Birthplace Darlington, S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace S. C.

MOTHER
14. Maiden Name ? Campbell
15. Birthplace S. C.

16 (a) Informant Mary Hill
(b) Address 1010 Harford Ave

17 (a) Removal (b) Date thereof 12/23/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory .....
Location Winston Salem, N. C.

18 (a) Funeral director Joseph D. Locks Jr.
(b) Address 130 N. Central Ave

19 DEC 22 1947 (b) Huntington Williams, M.D.
(Date filed by Registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1947, at 12.25 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cardiovascular disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Malecio M.D.
Medical Examiner.

Date signed 12-22-47

C58284 ✓ C58284

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 83a

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 Edmondson Ave ST., WARD)

REGISTERED NO.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abram M. Watson Abram M. Watson

(a) RESIDENCE NO. 1923 Edmondson Ave ST., WARD 20-1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Siegh Watson

6 DATE OF BIRTH (month, day, and year) Oct. 31, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER James Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Martha Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. Laura M. Watson 1923 Edmondson Ave.

15 Date DEC 23 1947 Registrar

CAUSE OF DEATH is part of PERSONAL AND STATISTICAL PARTICULARS on back of certificate. ATTENTION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 22, 1947

17 I HEREBY CERTIFY, That I attended deceased from June 6th, 1947, to December 22nd, 1947, that I last saw him alive on December 18th, 1947, and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Hypertension and Arteriosclerosis

Hemiplegia (duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. D. Kammer, M. D.

12-22 1947 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Thomas Cem. Garrison Forest

DATE OF BURIAL 12.24.47

20 UNDERTAKER WM. J. TICKNER & SONS INC

ADDRESS BALTO. MD.

G58285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G58285

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3039 Walbrook Ave.
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3039 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mark Worman

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry Repp Worman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1883

8. AGE: Years 64 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Botetourt Co. Va.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Americus C. Cronise
13. Birthplace Lewistown, Md.

MOTHER
14. Maiden Name Alice Bream
15. Birthplace Biglerville, Pa.

16 (a) Informant Mr. H. R. Worman
(b) Address 829 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery Mt. Olive
Location Frederick Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17. Md.

19 (a) DEC 23 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Dec. 22, 1947, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1947 to Dec. 22, 1947 and that I last saw h... alive on Dec. 22, 1947.

Immediate cause of death	Duration
Carcinoma of Liver	
Due to Metasestis into Stomach	
Due to and Lungs	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. H. C. Allen M. D.
Address 2757 W. Mos. Date signed 12/22/47

VS 150

G58286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G58286

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4315 Springdale Ave.
(c) Hospital or institution: 28-24

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4315 Springdale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma H. Gibson

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~or wife~~ Morrison Gibson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 23, 1862

8. AGE: Years	Months	Days	If less than one day
85	8	29	hr. min.

9. Birthplace Grafton W. Va. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Samuel Houston
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Graham
15. Birthplace Utica N. Y.

16 (a) Informant Mrs. Helen H. Littleton
(b) Address 4315 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Loudon Park
Location Baltimore Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto. 17, Md.

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1947, 19..., at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1947 to Dec 22 1947. and that I last saw h~~er~~ alive on Dec 22 19 47.

Immediate cause of death	Duration
Acute Coronary Occlusion	
+ Cerebral Vascular accident	6 hrs
Due to Generalized Arteriosclerosis	25 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. J. Abbott M.D.
Address 4509 Liberty Heights Date signed 12-23-47 M. D.

VS 150

C58287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C58287

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2826 N. Howard St.
(c) Hospital or institution: 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2826 N. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SOPHIA A HEIMILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~or wife~~ Herman T. W. Heimiller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1865

8. AGE: Years	Months	Days	If less than one day
82	11	19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Louis S. Schaum
13. Birthplace Germany

MOTHER
14. Maiden Name Carolina Moseley
15. Birthplace Norfolk Va.

16 (a) Informant Mrs. N. J. Maisel
(b) Address 2826 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery ~~Knollwood~~ Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

DEC 29 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945 to Dec 22 1947 and that I last saw h~~e~~r alive on Dec 22 1947

Immediate cause of death	Duration
Broncho-Pneumonia	2 days
Due to Cerebral Hemorrhage	2 weeks
Due to Arteriosclerotic Hypertension Colic Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Weinstein M.D.
Address 1927 E. North Ave. Date signed 12-28-47

58288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 58288

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 Clifton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard L Mann

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	Yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Amanda A. Mann
6 (c) If alive, give age? 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1882

8. AGE: Years	Months	Days	If less than one day
65	2	25	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Gustav Mann
13. Birthplace Germany

MOTHER
14. Maiden Name Matilda Kaemmel
15. Birthplace Germany

16 (a) Informant Wife
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto. MD.

18 (a) Funeral director (or) W. J. TICKNER & SONS INC
(b) Address North & Pa. Aves., Balto, MD.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

DEC 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1947 at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1947 to Dec 22 1947 and that I last saw h[illegible] alive on Dec. 22 1947.

Immediate cause of death Respiratory failure — Duration

Due to Diffuse carcinomatosis of lung — 72 hrs

Due to — prev

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/16/47

Major findings of operation: Diffuse carcinomatosis of parietal pleura

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gary M. Fox M. D.
Address Union Mem. Hosp. Date signed 12/22

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 658289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 1849 E. 29th St
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits write RURAL and give town)
(d) Street No. 2413 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stella L. Lohmeyer

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	DIVORCED

6 (b) Name of husband or wife: HARRY B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 13, 1869

8. AGE: Years	Months	Days	If less than one day
60	4	8	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name CHARLES LEAGUE
13. Birthplace —

MOTHER
14. Maiden Name MARTHA V SHARP
15. Birthplace BALTO.

16 (a) Informant MR. C. ROBERT LOHMEYER
(b) Address 1839 Lock Shire Rd, Towson, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location Balto, MD.

18 (a) Funeral director WM J. JICKNER & SONS INC
(b) Address North & Fa. Ave, Balto Md

19 DEC 23 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21 1947, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 12/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 658290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 N. Eden St
(c) Hospital or institution: S.I
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N. Eden st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mamie Corbins

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: William Corbins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-15-1882

8. AGE: Years	Months	Days	If less than one day
65	3	6	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Beautician

11. Industry or business

FATHER
12. Name George Commons
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name Annie Barnes
15. Birthplace Baltimore - Md.

16 (a) Informant Gladys Saunders
(b) Address 602 - N. Eden st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore - Md.

18 (a) Funeral director Preston Linbury
(b) Address 549 Mosher st.

19 (a) Dec 23 1947 (Date received by registrar) (b) Huntington Williamson, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 21 1947 11:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15/47 to 12/21/47 and that I last saw h[illegible] alive on 12/21/1947.

Primary cause of death: Nephritis and Arteriosclerosis — Duration: 6 mos 1 month

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 132 N. Central Ave
Date signed X 12-23-47.

VS 150

G58291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G58291 Registered No.

AB-115186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 735 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 1mo.?

3 (a) FULL NAME: William E. Sabin-or-William E. Sabins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2-1876

8. AGE: Years 71 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Well Digger

11. Industry or business

FATHER
12. Name William E. Sabin-or-William E. Sabins
13. Birthplace Minnesota

MOTHER
14. Maiden Name Annie ?
15. Birthplace Washington, D.C.

16 (a) Informa Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director John F. Denny, Inc
(b) Address 715 Light St.

19 DEC 23 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

V S/ 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21 1947, at 4Pm M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13- 1947 to 12-21 1947, and that I last saw him alive on 12-21 1947.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Generalized arteriosclerosis.	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Worley
Address Balto City Hosp Date signed 12-24-47

G58292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G58292

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST.
(c) Hospital or institution: MERCY HOSPITAL 21-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 27 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 OAKCREST AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JACOB LEON COLES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife DOROTHY COLES
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 13, 1882

8. AGE: Years	Months	Days	If less than one day
65	11	8	hr. min.

9. Birthplace NEW JERSEY (Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business EUGENE DIETZ & CO.

FATHER
12. Name George H. Coles
13. Birthplace N.J.

MOTHER
14. Maiden Name ELMA FIZLEY
15 Birthplace N.J.

16 (a) Informant ADMISSION NOTE
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto.

18 (a) Funeral director L.J. Ruck
(b) Address 5305 Harford Road

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21 1947 at 4 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13/ 1947 to 12/21 1947 and that I last saw h.im alive on 12/21 1947

Immediate cause of death CARDIAC FAILURE — Duration

Due to CORONARY THROMBOSIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elden H. Pratt M. D.
Address Mercy Hosp Date signed 12/24/47

X

G58293

BALTIMORE CITY HEALTH DEPARTMENT ✓ G58293
CERTIFICATE OF DEATH 94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1026 E. Balto St
(c) Hospital or institution: S-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 E Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena Blechman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 82 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob

13. Birthplace Germany

MOTHER 14. Maiden Name Bertha

15. Birthplace Germany

16 (a) Informant Irving Blechman

(b) Address 3818 Lesterbrook Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-47 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Friendship

Location

18 (a) Funeral director Jack Levin Inc.;

(b) Address 2400-02 Eutaw Place

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Interred Forest Hillsmere, Md. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-1947, at 9:28 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 to 12-22 1947 and that I last saw her alive on 12-22 1947

Immediate cause of death: coronary artery sclerosis, coronary thrombosis — Duration: years

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irving Blechman

Address 320 Eutaw St Date signed 12/23/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

658294 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital 20-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 S Smallwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Rosen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1852

8. AGE: Years	Months	Days	If less than one day
95			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Anna Rosen
(b) Address 607 S Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-47 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eutaw Place

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1947, at 2 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Fract Pelvis, Fract Tibia & fibula - Bilateral -
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 12-21-47 at 5:00 P.M. 20-5
(b) Where did injury occur Wilkens Ave & Smallwood St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck by auto

23. Signature Earl Royer M.D. Medical Examiner

Date signed 12-23-47

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

058295 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15.8
(c) Hospital or institution: Lyed Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Forest Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Krantter ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife KARL KRANTTER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 20 - 1865

8. AGE: Years	Months	Days	If less than one day
82	3	2	hr. min. 1985

9. Birthplace IRELAND
(Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant MRS. MARGARET SWAN
(b) Address 3306 FOREST PARK AVE

17 (a) BURIAL (b) Date thereof DEC. 24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location BALTO, MD.

18 (a) Funeral director THOMAS J. KENNY, INC.
(b) Address HOLLINS & GILMOR STS.

19 (d) DEC 23 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1947, 1225 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to C. O. poisoning

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15/8 5:50 A
(a) Date of injury 12-22-47 M.
(b) Where did injury occur? 3306 Forest Park Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NS
(d) Means of injury Inhalation of illuminating gas (gas burner open in kitchen)

23. Signature [signature] M.D.
Medical Examiner
Date signed 12/22/47

VS 191

X 128

658296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 658296

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 Bayard St
(c) Hospital or institution: 21-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Bayard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Friedlander

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Isador

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walter
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Isador Friedlander
(b) Address 1107 Bayard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-47 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Rewds Inc
(b) Address 2 So Eutaw Place

19 DEC 23 1947 (Date rec'd by registrar) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22- 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1947 to 12/22 1947, and that I last saw her alive on 12/22 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular disease	8 yrs
Due to a) Congestive Heart Failure	5 yrs
Due to b) Bronchopneumonia	1 wk
Due to c) Cerebral Hemiplegia	
Diabetes Mellitus	15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Feaver M. D.
Address 1 E Chase St Date signed 12-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

658297 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dec'd
(c) Hospital or institution: St Josephs Hospital 9.0
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Cole

3 (b) If veteran, name war: World War I.
3 (c) Social Security Account No. 217-05-8874
4. Sex: M
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 16 1890
8. AGE: Years 57 Months 8 Days 5 If less than one day hr. min.
9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Cole
13. Birthplace Prince George County, Md.

MOTHER
14. Maiden Name Hattie Martin
15. Birthplace Washington D.C.

16 (a) Informant Ruth Lee (Dept. Friend)
(b) Address 1838 N. Spring St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/47 (month) (day) (year)
(c) Cemetery or crematory Betts National
Location
18 (a) Funeral director Roberts Funeral
(b) Address 1216 N. Caroline St
19 (a) DEC 23 1947 Huntington Pittsburg Md. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/47 19 at 5:40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Peterson M.D. Medical Examiner.
Date signed 12/22/47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58298 D.C. 40185 — BALTIMORE CITY HEALTH DEPARTMENT — G58298 Registered No.

CERTIFICATE OF DEATH ✓ 181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3720 Falls Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JANET ~~Lee~~ Lockner ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 20, 1942

8. AGE: Years	Months	Days	If less than one day
5 yrs	5		hr. min.

9. Birthplace MARYLAND. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name DANIEL T. LOCKNER.
13. Birthplace MARYLAND.

MOTHER
14. Maiden Name MARY E. MARTIN.
15. Birthplace MARYLAND.

16 (a) Informant MARY E. LOCKNER.
(b) Address 3720 FALLS ROAD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 23 1947 (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Mary's
Location Hampden

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615-17 Edmondson Ave

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1947 at 12:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH 1st-2nd-3rd degree burns 65% body

Due to

Other Conditions 20% Carbon monoxide asphyxiation (Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/19/47 at about 6:10 P.M.
(b) Where did injury occur? 3720 Falls Rd
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Oil stove explosion

23. Signature C. J. Pulaski M.D. Medical Examiner.
Date signed 12/20/47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered 58299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hosp. 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3621 Roland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widower

6 (b) Name of husband or wife Alice J. Gall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1883

8. AGE: Years	Months	Days	If less than one day
64	7	14	hr. min.

9. Birthplace Iowa
(Town, county, and state)
10. Usual Occupation Saw Filer.
11. Industry or business

FATHER
12. Name George C. Gall.
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Johnston.
15. Birthplace Iowa

16 (a) Informant Glenn F. Gall.
(b) Address 5507 Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn.
Location

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Edmondson Ave.

19 (a) ~~Dec 22 1947~~ (Date rec'd by local reg'r) (b) ~~Huntington Hillman~~ Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1947, at 6 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1947 to 12/20 1947 and that I last saw h~~im~~ alive on 12/20 1947

Immediate cause of death	Duration
Respiratory failure;	
shock	
Due to Metastatic lymphosarcoma — probably Hodgkin's Dis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature D S Phillips
Address Univ. Hosp Date signed M. D. 12/21/47

×

658300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

658300 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3461 Keswick Rd.
(c) Hospital or institution: 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3461 Keswick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Newcomer.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-4462

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary A. Newcomer

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) May 18, 1894

8. AGE: Years	Months	Days	If less than one day
53	7	4	hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Plumber.

11. Industry or business L.C. Mitchell Co

FATHER — 12. Name Frank P. Newcomber.

13. Birthplace Pa

MOTHER — 14. Maiden Name Lavina Smithacker.

15. Birthplace Pa.

16 (a) Informant Mary A. Newcomer.

(b) Address 3461 Keswick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 1947 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn, Md.

18 (a) Funeral director Edgewood Memorial

(b) Address 3405 Edgewood Ave.

19 DEC 22 1947 (Date received by registrar) (b) Hunting for Williamson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to Dec. 22 1947, and that I last saw h[illegible] alive on Dec 21 1947

Immediate cause of death: Coronary Thrombosis. — Duration: 5 min.

Due to arteriosclerosis generalized — 6 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elbert H. Mortensen Jr. M.D.

Address 2706 E. Pratt St. Date signed 12/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G58301 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Heldon Avenue
(c) Hospital or institution: 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Heldon Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Rice

3 (b) If veteran, name war —
3 (c) Social Security Account No. Unknown

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Margaret J. Rice
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 30-1856
8. AGE: Years 91 Months 7 Days 22 If less than one day hr. min.
9. Birthplace York Co. Pennsylvania (Town, county and state)
10. Usual Occupation Gatchman - Poole Foundry & Machine
11. Industry or business Retired 5 years

FATHER
12. Name Lewis Rice
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Feller
15. Birthplace Germany

16 (a) Informant J. Edward Rice
(b) Address 1317 Heldon Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24-1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) DEC 23 1947 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22- 1947 at 4:30 A.M
21. I certify that death occurred on the date above stated; that I attended deceased from 12/1/ 1947 to 12/22 1947 and that I last saw h alive on 12/21 1947

Immediate cause of death	Duration
Bronchitis 1 day	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 2020 W. Clare Date signed 12/24/47

VS 150

RICHARD M. HORNSBY

C58302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1864

Registered No. C58302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write R.F.D. and give town)
(d) Street No. 3738 Seneca Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard M. Hornsby

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-01-3020

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Daisy G. Hornsby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21-1881

8. AGE: Years	Months	Days	If less than one day
66	—	—	hr. min.

9. Birthplace Baltimore Maryland (Town, county and state)

10. Usual Occupation Clerk

11. Industry or business Bel-Mar Corp.

FATHER 12. Name Robert M. Hornsby

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Catherine Lowman

15. Birthplace Maryland

16 (a) Informant Miss Ada Elizabeth Hornsby

(b) Address 3436 Seneca Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24-1947 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Frederick Road

19 (a) DEC 29 1947 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Dec 1947, at 7:54 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of Skull & intra-cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-13-47 at about 1 P.M. (b) Where did injury occur? Fell while walking ? victim at the location from Seneca Street

(c) Did injury occur at home, on farm, industrial place, in public place? R.R. Prop. While at work? No

(d) Means of injury fell down embankment

23. Signature Earl L. Kaylor M.D. Medical Examiner.

Date signed 24 Dec 47

VS 181

X 475

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658303

BALTIMORE CITY HEALTH DEPARTMENT

WAGNER CERTIFICATE OF DEATH 94a

Registered No. 658303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 N. Rose St.
(c) Hospital or institution: 7-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 708 N. Rose St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country X

3 (a) FULL NAME Leonard Peter Wagner

3 (b) If veteran, name war: 11 World War | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife: Mildred Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22/1902

8. AGE: Years 45 | Months 5 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Miss.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Copper

FATHER
12. Name Martin Wagner
13. Birthplace Calhoun

MOTHER
14. Maiden Name Amelia Farber
15. Birthplace Miss

16 (a) Informant Mrs. Mildred Wagner
(b) Address 708 N. Rose St.

17 (a) Buried (b) Date thereof Dec 26/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Maryland Mem. Pk.
Location Baltimore

18 (a) Funeral director Philip Hamilton
(b) Address 2024 Maryland Ave

19 (a) DEC 23 1947 (b) Huntington Avenue, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-1947, at 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 15 1947 to Dec. 22 1947 and that I last saw h alive on 12-21 1947.

Immediate cause of death
Coronary Thrombosis — 5 hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. Nelson M. D.
Address 3 W. Biddle (Address of signer) 12-22-47

VS 156

058304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

058304 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 White Ave.
(c) Hospital or institution: 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 White Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Everard Stellfox

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Ethel Seitz Stellfox
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) May 28, 1876

8. AGE: Years	Months	Days	If less than one day
71	7	25	2 hr. 6 min.

9. Birthplace Jamaica, W. In.
(Town, county, and state)
10. Usual Occupation Stationary engineer (retired)
11. Industry or business 1st National Bank

FATHER
12. Name John Stellfox
13. Birthplace Jamaica, England.

MOTHER
14. Maiden Name Wilhelmina Robinson
15. Birthplace Jamaica, W. I.

16 (a) Informant Mrs. Everard Stellfox
(b) Address 3814 White Ave.

17 (a) burial (b) Date thereof 12/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director Lasaahn Funeral Home
(b) Address 7401 Belair Road

19 (a) DEC 23 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1947, at 7.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4th 1947, to Dec 23 1947, and that I last saw him alive on Dec 22 1947.

Immediate cause of death	Duration
Coronary thrombosis	20 d
Due to Coronary disease onset June	5, 1939
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 12/23/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658305 (658305) 1179a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3304 Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d.
(e) Length of stay in Baltimore (yrs., mos., or days) ? 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7042 Belclare Rd. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Steiger

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Anna Steiger
6 (c) If alive, give age 745 years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1899

8. AGE: Years	Months	Days	If less than one day
48	3	13	hr. min.

9. Birthplace Mercersburg, Penna. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name George Steiger
13. Birthplace Hanover, Pa.

MOTHER
14. Maiden Name Virginia Frieg
15. Birthplace Fort Loudon, Pa

16 (a) Informant Wife
(b) Address Same

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 26, 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Mercersburg, Pa.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

DEC 23 1947 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1947, at 3 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1947, to Dec 22 1947, and that I last saw h im alive on Dec 22 1947.

	Duration
Immediate cause of death Gastric hemorrhage.	2d.
Due to marginal ulcer following gastroenterostomy	17 yrs.
Due to perforated peptic ulcer	16 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide NO
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jas. Martin Fox M. D.
Address Union Mem. Hosp. Date signed 12/22/47

VS 150

G58306 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. G58306

CERTIFICATE OF DEATH 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5925 Sefton Avenue
(c) Hospital or institution: 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5925 Sefton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANTON JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Annie Jones
6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) Dec. 11 1872

8. AGE: Years	Months	Days	If less than one day
75	0	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Retired

FATHER
12. Name Charles A. Jones
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Rider
15. Birthplace Germany

16 (a) Informant Mrs. Annie Jones
(b) Address 5925 Sefton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

DEC 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1947, at 10/30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to Dec 21 1947, and that I last saw h/M alive on Dec 20 1947

Immediate cause of death	Duration
arteriosclerotic Heart Disease	3 yrs.
Due to Generalized arteriosclerosis	5 yrs.
Due to	
Other Conditions Chronic Prostatitis, Chronic nephritis	2 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Sander M. D.
Address 4808 Harford Rd. Date signed 12/24/47

937 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G58307

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorento Road
(c) Hospital or institution: COLONIAL NURSING HOME 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 E. 20th. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT THOMAS ROCHFORT

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	212-10-3426

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Beulah M. Rochfort
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr) Jan. 6, 1883

8. AGE: Years	Months	Days	If less than one day
64	11	15	hr. min.

9. Birthplace BALTIMORE, MD.
(City, county, and state)
10. Usual Occupation Clerk
11. Industry or business Md. Casualty Co.

FATHER
12. Name Martin H. Rochfort
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bertha Hall
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Beulah M. Rochfort
(b) Address 1116 E. 20th. Street

17 (a) Burial (b) Date thereof 12/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 23 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1947, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947, to Dec 1947, and that I last saw h alive on 12-21 1947.

Immediate cause of death	Duration
Acute Heart Failure	1 Hour
Due to Hypertension	Jan 1942
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury FEARING
23. Signature William L. Fearing M. D.
Address 3025 Belair Rd Date signed 12-22-47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183a

Registered No. 658308

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 144 S. Ellwood Ave.
(c) Hospital or institution: 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 144 S. Ellwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK JOSEPH ZIMMERER

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Katherine R. Zimmerer
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1891

8. AGE: Years	Months	Days	If less than one day
82	1	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation U.S. Coast Guard
11. Industry or business U.S. Gov't.

FATHER
12. Name Henry Zimmerer
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Lang
15. Birthplace Germany

16 (a) Informant Mrs. Katherine R. Zimmerer
(b) Address 144 S. Ellwood Avenue

17 (a) Burial (b) Date thereof 12/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 DEC 22 1947 (Date received by registrar) Huntington Williams (Registrar)

VS 189

MEDICAL CERTIFICATION X

20. DATE OF DEATH December 21 1947, at 10.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Dec 21 1947.
And that I last saw him alive on Dec 21 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	6 mos.
Bronchiectasis	3 yrs. +
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George D. Lofting M. D.
Address 4321 Pattison Park Rd. Date signed 12/22/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658309

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 655 09

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3032 Poplar Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
Baltimore, Md.
(c) City or town 1217 Leeds Terrace Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA V. BURGOON

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband ~~or wife~~ John W. H. Burgoon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1865

8. AGE: Years	Months	Days	If less than one day
82	1	6	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name John Frock
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Matilda Miller
15 Birthplace Carroll Co. Md.

16 (a) Informant Mr. John W. H. Burgoon
(b) Address 1217 Leeds Terrace Arbutus

17 (a) Burial (b) Date thereof 12/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~xxxxxxxxx~~ Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 DEC 23 1947 (b) Livingston Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 22, 1947 at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1947 to Dec 22 1947, and that I last saw her alive on Dec 22 1947.

	Duration
Immediate cause of death: Cardiac Asthenia	4 hr.
Due to: Myocarditis.	5 yr.
Due to: Enlarged Heart	5 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. M. Coombs M.D.
Address 1202 St Paul St Date signed 12/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124 B

Registered No. 58310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 39
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Alleghnay
(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 E. MAIN ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Crowe Charles

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-0128

4. Sex M

5. Color or race Wh.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Novella Crow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 26, 1905

8. AGE: Years 42 | Months 10 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name Charles Crow
13. Birthplace md

MOTHER
14. Maiden Name Clara Sweene
15. Birthplace md

16 (a) Informant Hosp. Record
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 23 1947 (month) (day) (year)
(c) Cemetery or crematory ALLEGHANY
Location FROSTBURG, MD

18 (a) Funeral director J. DURST
(b) Address FROSTBURG, MD.

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1947, at 6 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 22 1947, and that I last saw him alive on Dec 22 1947.

Immediate cause of death	Duration
Massive hemorrhage from esophageal varices	
Due to	
Due to	
Other Conditions Uremia ? Hepato-renal insufficiency	

(Include pregnancy within 3 months of death)

Date of operation Dec 6-1947

Major findings of operation: Splenomegaly, portal cirrhosis ↑

of autopsy: Splenomegaly

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo Greene Jr M.D.
Address Memo. Hosp. Date signed 12/22/47

VS 150

658311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658311

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Tenn. (b) County
(c) City or town Knoxville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME James Thorsen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Beatrice Humphreys
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Unknown.

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace Knoxville Tenn.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Frederick Thorsen
13. Birthplace Tenn.

MOTHER
14. Maiden Name Jena Thorsen
15 Birthplace Tenn.

16 (a) Informant Howard Yount
(b) Address 601 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28-47 (month) (day) (year)
(c) Cemetery or crematory Knoxville
Location Knoxville Tenn

18 (a) Funeral director Chas P Powell
(b) Address 3127 Edmondson Ave

19 (a) DEC 23 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1947, to 12/23 1947, and that I last saw him alive on 12/23 1947.

	Duration
Immediate cause of death Uremia	Apparent
Due to Cholemia	0 1 2 7 yrs.
Due to Cirrhosis	Unknown
Other Conditions Right bundle branch block, pleural effusion	Unknown.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Collaborative Clinical

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry V. Chase M. D.
Address Mercy Hospital Date signed 12/24/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 58312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Shady Nook Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph William Gosnell

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife May 13, 1891
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1891

8. AGE: Years	Months	Days	If less than one day
56	5 7	10	hr. min.

9. Birthplace Cedar Rapids, Iowa
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry Gosnell
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Bertha Van Steenwyke
15. Birthplace Pelhan, Iowa

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 12-26-47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~crematory~~ Morgan Chapel
Location Day, Carroll Co. Maryland

18 (a) Funeral director C. M. Waltz
(b) Address Winfield, Md.

19 DEC 23 1947 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1947, at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1947, to Dec. 23 1947, and that I last saw h in alive on Dec. 23 1947.

Immediate cause of death Carcinoma bronchogenic left upper lung with metastases to ribs and — Duration: Unknown
~~Due~~ to adrenals

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/23/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1104

Registered No. B-58313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dundalk + Rayner Aves
(c) Hospital or institution: West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 94 Hanover Court (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) **FULL NAME** Barbara Bryant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Arnold E. Bryant

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) 4 9

8. AGE: Years 28 | Months — | Days — | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Mr. Brown

13. Birthplace Romania

14. Maiden Name Mrs. Brown

15. Birthplace Romania

16 (a) Informant Mrs Arnold E Bryant

(b) Address 94 Hanover Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem

Location Gor Reisterstown Rd

18 (a) Funeral director Milton Sibilsky

(b) Address 3860 Hanover Ave

19 (a) [illegible] (Signature of Registrar) Registrar for Baltimore, Md

DEC 24 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1947 to 12-23 1947, and that I last saw her alive on 12-23 1947.

Immediate cause of death: Pneumonia — Lobar — Bilateral — Duration

Due to: Acute Lupus

Due to: Erythematosus Disseminatus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Benjamin Berkowitz M. D.

Address West Balto Gen'l Hosp Date signed 12/27/47

X

G58314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

837

Registered No. G58314

CM. 115662

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 18 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 N. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kathryn Marlowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SEP.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13 -1885

8. AGE: Years	Months	Days	If less than one day
62	10	9	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? ~~Levy~~ Frank Levy
13. Birthplace Bohemia

MOTHER
14. Maiden Name Anna ?
15. Birthplace Czechaslovakia

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Frank Gorsch Son
(b) Address 700 N. Eberstart

19 (a) DEC 24 1947 (b)
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 - 1947, 5.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12- 4 - 1947 to Dec. 22- 1947, and that I last saw her alive on Dec. 22 1947

Immediate cause of death	Duration
Bronchopneumonia.	
Due to Cerebral Vascular Accident & Hemiplegia	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Kerkam M.D.
Address Balto City Hosp. Date signed 23 Dec. 47

X

G58315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1463

G58315 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5866 Belair Road
(c) Hospital or institution: 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5866 Belair Road 6 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Machacek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alois Machacek

6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 78 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mathew Novy

13. Birthplace Bohemia

MOTHER 14. Maiden Name Barbara Cacha

15. Birthplace Bohemia

16 (a) Informant Alois Machacek

(b) Address Bohemia

17 (a) Burial (b) Date thereof 12-24-47 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Oak Hill

Location Baltimore, Md.

18 (a) Funeral director Frank Lynch & Son

(b) Address 900 N. Chester Street

19 (a) DEC 24 1947 (Date rec'd by registrar) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21-1947, at 2:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15, 1947 to 12-21-1947, and that I last saw her alive on 12-20-1947

Immediate cause of death Carcinoma of the Stomach — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Wilkinson, M. D.

Address 5713 Bel Air Rd Date signed 12-22-47

X Balt. 6.

VS 150

65313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 65316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2044 Spaulding Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ben Wolsk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Meyer
13. Birthplace Russia

MOTHER 14. Maiden Name Ethel
15. Birthplace Russia

16 (a) Informant Leroy Libel
(b) Address 2044 Spaulding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-47 (month) (day) (year)
(c) Cemetery or crematory Location Buffalo N. Y.

18 (a) Funeral director Herbert Leroy Libel
(b) Address 710 Eutaw Place

(a) DEC 24 1947 (b) [illegible] registrar [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 December 1947 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1947 to 12-23 1947, and that I last saw h[illegible] alive on 12-23 1947

Immediate cause of death	Duration
Cardio - Respiratory failure	
Due to Ca. of Small Bowel & Intestinal Obstruction and generalized Carcinomatosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12-2-47
Major findings of operation: Ca. of Small Bowel - Carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Tyler H. Lerman M. D.
Address Sinai Hosp Date signed 12-23-47

G58317 Ovi. 3 Dr Kelly

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 518

G58317 Registered No. 43421

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 N. Linwood Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Albert Bond

3 (b) If veteran, name war

3 (c) Social Security Account No. 202-03-9331

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary C. Bond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-2-1879

8. AGE: Years 68 | Months 3 | Days 21 | If less than one day .....hr. .....min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Caleb Bond
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary
15. Birthplace Maryland

16 (a) Informant Mary E. Bond
(b) Address JOHNS HOPKINS HOSPITAL 723 N. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Taylor Ave

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 6009 Harford Road

DEC 24 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-23 1947 at 6.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1947 to 12-23 1947 and that I last saw him alive on Dec 23 1947

	Duration
Immediate cause of death Uremia	2 wks
Due to Ureteral obstruction	
Due to Carcinoma of prostate	4 wks
Other Conditions Metastasis to Liver	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature James F Carson M. D.
Address Johns Hopkins Hosp Date signed 12-22

G58318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G58318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2512 West Pratt Street
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2512 West Pratt Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN LOTZ

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-0512

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna E. Lotz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1874

8. AGE: Years	Months	Days	If less than one day
73	10	30	********** hr. ********** min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Baker - Retired
11. Industry or business Retired

FATHER
12. Name John Lotz Sr.
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret (unknown)
15. Birthplace Germany

16 (a) Informant Mrs. Anna E. Lotz (wife)
(b) Address 2512 West Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Maryland

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE....17

DEC 24 1947 (a) registrar Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21/47, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1947 to Dec 21 1947, and that I last saw him alive on Dec. 21 1947

Immediate cause of death	Duration
Cardiac Asthenia	2 hrs
Coronary occlusion	9 da
Due to cardiac Detatation.	24 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. W. Kemp M.D.
M. D.
Address 1206 St. Paul St. Date signed 12/ /47

G58319 LW 115293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

G58319 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 E. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Fannie Keating

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27- 1891

8. AGE: Years	Months	Days	If less than one day
56	3	25	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Lowery (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Covington
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilburn & Dorsey
(b) Address 1314 Park Ave

19 DEC 24 1947 (By the date registrar) (By) Keating for Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1947, at 2:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17- 1947, to 12-22- 1947, and that I last saw her alive on 12-22 1947.

Immediate cause of death	Duration
Coronary Thrombosis	5 min.
Due to Coronary Artery Sclerosis	3 Years
Due to	
Other Conditions Carcinoma of Colon	1 Year

(Include pregnancy within 3 months of death)
Date of operation 12-8-47 & 12-11-47
Major findings of operation: Ca of Colon. Pertinent Access
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. Yeoke M. D.
Address 4940 Eastern Ave Date signed 12-22-47

94A

G58320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192B

G58320 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 430 S. Smallwood St
(c) Hospital or institution: 20-S

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 S. Smallwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Barbara Keffler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Geo. Herman

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Dec 17, 1876

8. AGE: Years	Months	Days	If less than one day
71	0	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name Henry Greffen
13. Birthplace Germany

MOTHER 14. Maiden Name Sophie Bolwick
15. Birthplace Germany

16 (a) Informant Mrs Elsie Lloyd
(b) Address 430 S. Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Ave

18 (a) Funeral director John F Kenny Inc
(b) Address 714 Light St.

19 (a) Dec 24 1947 (b) Registrar Hampton Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1947, at 6 10 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1947, to 21 1947, and that I last saw her alive on Dec 21 1947.

Immediate cause of death Pulmonary Edema,
Due to Acute Cardiac Failure
Due to Hypertension.
Other Conditions Partial Incontinency

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hampton C. Williams M.D.
Address 215 N. Wilkens Ave Date signed 12/24/47

C58321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

Registered No. C58321

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Fernhill Ave
(c) Hospital or institution: 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Fernhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Lehrer

3 (b) If veteran, name war
3 (c) Social Security Account No. 216-05-6635

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Jack
13. Birthplace Russia

MOTHER
14. Maiden Name Naomi
15. Birthplace Russia

16 (a) Informant Anna Lehrer
(b) Address 4008 Fernhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis, Inc
(b) Address 2160 Eutaw Place

19 DEC 24 1947 (Date rec'd by registrar) Beatrice for Williams M.R. (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23-1947, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1947, to Dec 23 1947 and that I last saw h alive on 12-23 1947.

Immediate cause of death	Duration
Acute pulmonary hemorrhage	6 hrs
Due to Carcinoma of lung	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Lemmon M. D.
Address 4004 Liberty Hgts Ave Date signed 12-24-47

X

G58322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G58322

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution: Mt Carmel Home 5-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1590 Woodland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Shapiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Aaron
13. Birthplace Russia

MOTHER
14. Maiden Name Shana
15. Birthplace Russia

16 (a) Informant Mrs Sarah Alterman
(b) Address 3514 Woodland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 740 Eutaw Place

DEC 24 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23-1947, at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1939 to Dec 23 1947, and that I last saw h alive on Dec 23 1947.

	Duration
Immediate cause of death: Arteriosclerotic cardio-vascular disease	10 yrs
Due to: Generalized Arteriosclerosis	
Due to:	
Other Conditions: Fractured left femur (Include pregnancy within 3 months of death)	4 mos

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/3
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec 12 1947 at 10 A.M.
(c) Where did injury occur? 1570 Woodland Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No (Specify type of place)
(e) Means of injury Fall in pavement

23. Signature Albert J. Shochet M.D.
Address 2302 Edmondson Ave Date signed 12/23/47 M. D.

Howard J. Madison, M. D.

G58323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G58323 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State S.C. (b) County
(c) City or town Beaufort S.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Goodman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name David
13. Birthplace Poland

MOTHER 14. Maiden Name Gertzyde
15. Birthplace Poland

16 (a) Informant B-L Goodman
(b) Address 6111 Hampstead Ave Richmond Va

17 (a) Burial (b) Date thereof 12-26-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington
Location Rogers Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 DEC 24 1947 Certificate for Williams Mortuary
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Dec 1947, at 6 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from 21 Dec 1947 to 22 Dec 1947, and that I last saw him alive on 22 Dec 1947.

	Duration
Immediate cause of death Peritonitis	
Due to Possible ruptured ulcer or perforated gastric carcinoma	
Due to	
Other Conditions Anemia Arteriosclerosis Heart disease	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard H Pratt
Address Sinai Hosp. Date signed 12-22-47

G58324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

G58324
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1830 E North Avenue
(c) Hospital or institution: 8-S
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 79-8-7

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1830 E North Avenue
(If rural give location)
(e) Citizen of foreign country? has (Yes or No)
If yes, name country

3 (a) FULL NAME Joanna Seal Hipple

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William C. Hipple
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1868

8. AGE: Years 79 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation Housework At Home

11. Industry or business

FATHER
12. Name Henry Seal
13. Birthplace Winchester Va

MOTHER
14. Maiden Name Joanna Pyle
15. Birthplace Winchester Va

16 (a) Informant Mrs Jasper Rinzer
(b) Address 1836 E North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Gorsuch Ridge St

18 (a) Funeral director Albert L Huth
(b) Address 1606 N Chester Street

DEC 24 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1947, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to Dec. 23 1947, and that I last saw her alive on Dec. 22 1947.

Immediate cause of death: Chronic Hypertrophic Degeneration — Duration 2 yrs +
Due to
Due to
Other Conditions: Chronic Arthritis — 5 yrs +
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Schneider M. D.
Address 1101 N. Wilton Ave Date signed 12-23-47

C58325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Reg. No. C58325

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Northway Drive.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3008 Northway Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Stratos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife. Stella Lambros

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 67 | Months - | Days - | If less than one day hr. min.

9. Birthplace Greece - Sparta
(Town, county, and state)

10. Usual Occupation Cook.

11. Industry or business

FATHER
12. Name [illegible] John.
13. Birthplace [illegible] Greece

MOTHER
14. Maiden Name Bertha.
15. Birthplace Greece

16 (a) Informant Bertha Carelas.
(b) Address 3008 Northway Dr.

17 (a) [illegible] 12-26-47 (b) Date thereof 12-26-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greek Cem.
Location Windsor Mill Rd

18 (a) Funeral director Lambros F. H. Inc.
(b) Address 440 E. North ave

(a) DEC 24 1947 (b) [illegible]
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/1947 at 6a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18-1946 to 12-23-1947. and that I last saw h alive on Oct 10 1947.

Immediate cause of death	Duration
Coronary Embolism	
Due to Coronary sclerosis -	since 10/18/46.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1517 E. North Ave. Date signed 12/23/47. M. D.

G58326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58326

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2654 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2654 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Esther Lee O'Neill

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced.
Female	White	Widow

6 (b) Name of ~~husband~~ or wife Late James T

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 - 1879

8. AGE: Years	Months	Days	If less than one day
68	7	22	hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation

11. Industry or business at Home

FATHER 12. Name Frank W. Lee

13. Birthplace Nova Scotia

MOTHER 14. Maiden Name Esabella Forsythe

15. Birthplace Ireland

16 (a) Informant Frank L. O'Neill

(b) Address 2654 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Ca Cathedral

Location Old Frederick Road

18 (a) Funeral director John C Horgan

(b) Address 3000 Baltimore St

Dec 24 1947 (a) Date received by registrar (b) Washington Ville, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1947 to Dec 23 1947, and that I last saw h~~er~~ alive on Dec 22 1947.

Immediate cause of death	Duration
Apoplexy	3 Days
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fritz J Illmer M. D.

Address 2700 Hartford Rd Date signed Dec 23 1947

83a

G58327 — BALTIMORE CITY HEALTH DEPARTMENT — G58327 Registered No.

CERTIFICATE OF DEATH

X 55E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address /
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town ~~Balto~~ Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fennimore Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amy M. Robbins

3 (b) If veteran, name war: X
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife Dwight A.
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) May 25-1896

8. AGE: Years	Months	Days	If less than one day
51	7	3 28	hr. min.

9. Birthplace New Haven Conn. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Harvey Britton
13. Birthplace Pa

MOTHER
14. Maiden Name Amelia
15. Birthplace Pa

16 (a) Informant Mr. Dwight Robbins
(b) Address Fennimore Lane

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 23 47 (month) (day) (year)
(c) Cemetery or crematory Lawndale
Location Penna

18 (a) Funeral director Blair Connelly
(b) Address 408 Eastern Ave.

19 (a) DEC 24 1947 (Registered by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1947, at 11 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1947 to 12/22 1947, and that I last saw her alive on 12/22 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: autopsy Pneumonia
Carcinomatosis of Lymphnodes (Primary site?)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hosp Date signed 12/23/47

VS 150 Huntington Williams, M.D.

830

G58328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G58328 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 S. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ABOVE ADDRESS 56 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 S. CALHOUN St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) **FULL NAME** EMMA C. ENSOR

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 19, 1858

8. AGE: Years 89 | Months 0 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business @

FATHER
12. Name HENRY NICHOLSON
13. Birthplace Balto. MD.

MOTHER
14. Maiden Name KATE MACHEN
15. Birthplace Va

16 (a) Informant Miss DAISY E. ENSOR
(b) Address 303 S. CALHOUN ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/26/47 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEM.
Location BALTIMORE MD.

18 (a) Funeral director WM. J. TURNER & SONS INC
(b) Address NORTH & PA. AVES. BALTO. MD.

19 (a) DEC 24 1947 (Date rec'd by registrar) (b) Evington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 23 1947, at 11 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1947 to 12/23 1947 and that I last saw h alive on 12/23 1947

Immediate cause of death: Fracture of
Due to: left hip
Due to:
Other Conditions: Bronchopneumonia

Duration: 1 day. / / / 2 days

(Include pregnancy within 3 months of death)
Date of operation 11/18/47
Major findings of operation: fractured left hip
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 11/16/47 at 6:00 M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? No
(Specify type of place)
(e) Means of injury fell down Injury
23. Signature Benjamin Weeks M.D.
Address 3030 W. Fillmore Date signed 12/24/47

H.J. Maddox MD / A.A. Merrill MD

G58329

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G58329
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Clara E. Steeger

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Theodore L. Steeger
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 12 1870

8. AGE: Years 77 | Months 10 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Christian Wahn
13. Birthplace Germany

MOTHER
14. Maiden Name Clara Trautmeyer
15. Birthplace Germany

16 (a) Informant Mr. Henry E. Mick
(b) Address 3708 Calloway Ave. 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/47 (month) (day) (year)
(c) Cemetery ~~OCCIDENTAL~~ Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1947 at 2.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1947 to Dec 23 1947, and that I last saw h~~er~~ alive on Dec 22 1947

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertension CVD & Failure.	
Due to	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jose H. Valderas M.D.
Address St. Agnes' Hospital Date signed 12-23-47

58330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G58330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Balto. Gen Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 N. Patterson Pk. Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louise O Ott

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife GEORGE OTT
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) JUNE 6 - 1879

8. AGE: Years	Months	Days	If less than one day
68 yrs.	6	17	____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? SANDER
13. Birthplace GERMANY

MOTHER
14. Maiden Name ? UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant GEORGE ROWE OTT
(b) Address 804 N. PATTERSON PARK AVE

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof 12/26/47 (month) (day) (year)
(c) Cemetery or crematory LAUDAN PARK
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 W. Mt. Royal Ave

19 (a) DEC 24 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1947, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20/47 19___, to 12/23 1947, and that I last saw her alive on 12/22 1947

Immediate cause of death	Duration
Cerebral Embolism	
Due to Hypertensive cardio vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Gordon Brown M. D.
Address WBGH Date signed 12/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106a

G58331 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Merrittsville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Catherine~~ Sandra Dunsler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed~~, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28-1946

8. AGE: Years	Months	Days	If less than one day
	11	27 26	hr. min.

9. Birthplace Merrittsville, Md. (Town, county, and state)

10. Usual Occupation Nurse.

11. Industry or business

FATHER
12. Name ~~Charles~~ Dunsler
13. Birthplace Md.

MOTHER
14. Maiden Name ~~Catherine~~ Adele Baker
15. Birthplace Md.

16 (a) Informant Mother Adele Dunsler
(b) Address Merrittsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Springfield
Location Ilchester, Md.

18 (a) Funeral director John O. Mitchell & Son Inc
(b) Address 1900 Eutaw Place,

19 (a) DEC 28 1947 (Date rec'd by Registrar) (b) ~~Huntington Wills~~ Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1947, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1947, to 12-23 1947, and that I last saw ~~her~~ alive on 12-23 1947

Immediate cause of death acute tracheo bronchitis ~~Contributory~~ — Duration

Due to Prog. failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. P. Meadenhall Jr M. D.
Address University Hospital Date signed 12-23-47
Balto., Md

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58332 / 832a

Registered No. G58332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Parkheights Ave
(c) Hospital or institution: 15 41
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 N Hilton Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ray Or Rachael Rudolph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace: New York City
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Hyman Brown
13. Birthplace: Russia

MOTHER
14. Maiden Name: Fannie ?
15 Birthplace: Russia

16 (a) Informant: Sol Rudolph
(b) Address: 3505 N Hilton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 25, 1947 (month) (day) (year)
(c) Cemetery or crematory: Beth Tfilon Cemetery
Location: Windsor Mill Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) (Date received by registrar) (b) Registrar

DEC 24 1947

V. S. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1947, at 6:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1947, to 12/23 1947, and that I last saw h/w alive on 12/23 1947.

Immediate cause of death	Duration
Acute Cerebral Hemorrhage	
Due to Ch Arterio Sclerosis	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 704 E Biddle St Date signed 12/24/47

Dr. Michael Abrams
1820 Eutaw Place

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G58333 / 12/a

Registered No. G58333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution:
Shriners Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5302 Carter Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C. Barnickel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John Barnickel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1876

8. AGE: Years	Months	Days	If less than one day
71	5	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Andrew Will
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Hochlein
15. Birthplace Germany

16 (a) Informant Fr. Will
(b) Address 16 S. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) DEC 24 1947 (Date rec'd by registrar) Huntington Hollins, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22nd 1947, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1944, to Dec 22 1947, and that I last saw h.er alive on Dec 22 1947.

Immediate cause of death	Duration
Cardio renal failure; Arth	8 days
Bychosis	
Due to Shock: Gastro Enteritis	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Michael A. Abrams M.D.
Address 1820 Eutaw place Date signed Dec. 24 47
M. D.

X

C58334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C58334

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4212 Harford Terrace (4)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John A. Startt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Julia F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12-1904

8. AGE: Years	Months	Days	If less than one day
43	10	12	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name John Startt, Jr.
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Sapp
15. Birthplace Md.

16 (a) Informant Mrs. Julia Startt
(b) Address 4212 Harford Terrace
17 (a) Burial (b) Date thereof 12/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.
18 (a) Funeral director L. J. Kuck
(b) Address 5305 Harford Rd.
19 (a) 12-24-1947 (b) Registrar Hilton Williams
(Date received by registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24 1947 at 1145 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22 1947 to 12-24 1947 and that I last saw h. alive on 12-24 1947.

Immediate cause of death	Duration
Coronary occlusion	
Due to Coronary thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. B. Moore M. D.
Address Univ. Hosp. Date signed 12-24-47

58335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 125B

Registered No. G58335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Pk Drive & 31st St

(c) Hospital or institution: U. S. Marine Hospital, Balto., Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2103 Division St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Calvert Ignatius Turner

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW II	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Irene Foxworth Turner

6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) April 17, 1914

8. AGE: Years	Months	Days	If less than one day
33	8	5	____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self-employed

FATHER

12. Name John F. Turner

13. Birthplace Charlestown, Md.

MOTHER

14. Maiden Name Eva Cooper

15 Birthplace Balto., Md.

16 (a) Informant Records

(b) Address U. S. Marine Hospital

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Dec. 26, 1947 (month) (day) (year)

(c) Cemetery or crematory Baltimore Nat'l

Location Baltimore, Maryland

18 (a) Funeral director Mrs. George H. Bullard

(b) Address 1631 Druid Hill Ave.

19 DEC 24 1947 Huntington Williams M.D.
(Registrar) (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1947 at 4.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from December 22, 1947 to Dec. 22, 1947 and that I last saw him alive on Dec. 22, 1947

Immediate cause of death Acute hepatitis — Duration Unknown

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John L. Wilson

John L. Wilson, Senior Surgeon M. D.

Address Clinical Director Date signed

U. S. Marine Hospital
Baltimore, Maryland

BRABSON

BALTIMORE CITY HEALTH DEPARTMENT

G58336 CERTIFICATE OF DEATH 1937

G58336 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 Calhoun St.
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr, 25 min
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write Yes and give town)
(1103) → 1104 (d) Street No. Holland St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Brabson

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) (Single) married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 31, 1882

8. AGE: Years 65 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Saw Worker

11. Industry or business Cotch Construction Co.

MOTHER / FATHER

12. Name Unknown

13. Birthplace Unknown.

14. Maiden Name Unknown

15. Birthplace Unknown.

16 (a) Informant Alice Janapp

(b) Address 1103 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab

(b) Address 2101 Frederick ave.

19 DEC 29 1947 (Date rec'd by registrar) (b) Thos Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1947 at 12:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 A.M. 12/24/1947, to 12:55 P.M. 12/27/1947, and that I last saw him alive on 12-24 1947.

Immediate cause of death: Cardiac failure

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph B. Schrock M. D.

Address Franklin Sq. Hosp. Date signed 12/27/47

G58337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

G58337
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Pr. Geo
(c) City or town Bowie (rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph McClelland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 191[illegible]

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David McClelland
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Higgs
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 12-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hyattsville
Location Hyattsville Md.

18 (a) Funeral director Francis Hauck Sons
(b) Address Hyattsville, Md.

25 (a) 19[illegible] Huntington Williams Registrar
(Date rec'd by registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1947, at 8 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1947, to 12/24 1947, and that I last saw him alive on 12/24 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral edema	
Due to Cirrhosis of liver with active bleeding esophageal varices	
Other Conditions Terminal Chronic alcoholism	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Evidence of above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D S Phillips M.D.
Address Court & Hoag Date signed 12/24/47

G58338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G58338 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2725 Riggs Ave
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2725 Riggs Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hiram L. Lewis

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) July, 1885

8. AGE: Years 62 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation

11. Industry or business Of Home

FATHER 12. Name Wm F. Kennard

13. Birthplace Va

MOTHER 14. Maiden Name Martha J. Stanley

15. Birthplace Va

16 (a) Informant Mrs Ernest Leslie

(b) Address 2725 Riggs ave

17 (a) Removal (b) Date thereof Dec 25th. (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Clarksburg Cem

Location Clarksburg Va

18 (a) Funeral director Sellrick Funeral Home

(b) Address 2005 Creedmore

25 1947 (a) (b) Clayton Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23-47 1947, at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2- 1947, to Dec 23 1947, and that I last saw her alive on Dec 23. 1947.

Immediate cause of death	Duration
Due to Carcinoma of Lung.	6 mos,
Due to Cardiac Dilatation & Exhaustion	few days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos Kyle C. Blake M. D.

Address Med. Arts Bldg. Date signed 12-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G58339 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave.
(c) Hospital or institution: Jenkins Memorial 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N. Monroe St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Caroline C. Anderson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1866

8. AGE: Years	Months	Days	If less than one day
81	10	4 5	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business —

FATHER
12. Name James Anderson
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine McHenry
15. Birthplace Ireland

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (b) Date thereof 12/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. D. Meade and Son
(b) Address 50[illegible] N. Gilbert St. Washington Building, Md.

19 (a) DEC 26 1947 (b) Registrar
(To be filled in by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1947, at 3:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1940 to Dec. 23 1947, and that I last saw her alive on Dec. 23 1947

Immediate cause of death: Congestive failure — Duration: —

Due to: Hypertensive cardiovascular disease — Duration: 7

Due to: — Duration: —

Other Conditions: Hemiplegia, right side due to cerebral hemorrhage — Duration: 1 yrs

(Include pregnancy within 3 months of death)

Date of operation not performed

Major findings of operation:

of autopsy: not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert J. Lewellen

Address Annapolis, Md. Date signed 12/24/47

G58340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 14

G58340
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Sheaf Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PATRICIA Cooper

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 1946

8. AGE: Years 1 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Cooper
13. Birthplace Pa.

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mother
(b) Address Same

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-28-47 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director J. L. McKenney
(b) Address 1003 Fort Ave

DEC 26 1947
(Date rec'd by registrar)

(c) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24-1947 at 3 26 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13-1947 to 12-24-1947 and that I last saw h[illegible] alive on 12-23-1947

Immediate cause of death: Respiratory Failure acute — Duration —
Due to: Intussusception 4 yrs ago Ileal — —
Due to: B Meningitis — 7 Mos
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: Partial ileal resection
of autopsy: B Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Charles R. Woodward M. D.
Address 1213 Light St Date signed 12-24-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

LW 93346 G58341 CERTIFICATE OF DEATH 95C Registered No. G58341

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 S. Caton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. McCormick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25- 1870

8. AGE: Years 77 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph T. McCormick (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Conner (D)
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Flynn - Fleming
(b) Address 1426 Light St.

19 (a) Filed (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24- 1947 at 2:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1945 to 12-24 1947, and that I last saw h 1m alive on 12-24 1947

Immediate cause of death — Duration

Bronchopneumonia

Due to organized ant. wall

Heart disease & auricular fibrillation — 2 days

Due to Generalized arteriosclerosis — years

Other Conditions Cerebral arteriosclerosis & malarkitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 12-24-47

G58342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1920

G58342
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 Riverside Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Riverside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Kenney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8- 1869

8. AGE: Years 78 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business —

FATHER
12. Name Thomas Kenney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kenny
15. Birthplace Ireland

16 (a) Informant Mrs Catherine Kenney
(b) Address 1417 Riverside Ave

17 (a) Burial (b) Date thereof 12-27-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto - Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

DEC 25 1947
(Date rec'd by registrar) (b)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23/47 19 to Dec 24 1947, and that I last saw h her alive on Dec 24 19 47.

Immediate cause of death	Duration
Chronic Endocarditis	1 mos.
Due to Arteriosclerosis	6 mos.
Due to Arterial Hypertension	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. B. Whelan M. D.
Address 1279 Williams St Date signed 12/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74A

Registered No. G58343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st St., & Wyman Pk. Dr.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Fishing Creek (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Langford Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Clara Travers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1886

8. AGE: Years	Months	Days	If less than one day
61	4	11	hr. min.

9. Birthplace Hoopersville, Md (Town, county, and state)
10. Usual Occupation Captain
11. Industry or business

FATHER
12. Name Benjamin Lewis
13. Birthplace Md.

MOTHER
14. Maiden Name Sallie Insley
15 Birthplace Md.

16 (a) Informant Hospital records.
(b) Address Marine Hosp., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/47 (month) (day) (year)
(c) Cemetery or crematory Dorchester Memorial Park
Location Cambridge, Md.

18 (a) Funeral director John O. Metcalf Sons Inc.
(b) Address 901 Eutaw Place

DEC 26 '94 (Date rec'd by registrar) (b) Huntington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1947, at 2:20a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1947 to Dec. 25 1947, and that I last saw h. im alive on Dec. 25 1947.

Immediate cause of death	Duration
Myelogenous leukemia	8 wks.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Woodman M.D.
Address Marine Hosp., Balto. Date signed 12/26/47

G58344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59A

G58344 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2021 E 30th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora E. Pelter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Howard L. Pelter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/5/76

8. AGE: Years	Months	Days	If less than one day
71	10	19	hr. min.

9. Birthplace at Cross
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Joseph Staltzer
13. Birthplace Pa.

MOTHER 14. Maiden Name Sarah M. Murnpe
15. Birthplace Pa.

16 (a) Informant Paul Pelter
(b) Address 2021 E. 30th St.

17 (a) Burial (b) Date thereof 12 27 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Johns Luth Cem
Location Lewistown Pa

18 (a) Funeral director Lemmon Funeral Home
(b) Address 2701 Belair Rd.

DEC 26 1947 Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24 1947 at 6:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to Dec 24 1947, and that I last saw her alive on Dec 24 1947.

	Duration
Immediate cause of death Cardiac Insufficiency	2 days
Due to Arteriosclerosis Rheumatoid Arthritis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mark R. English M. D.
Address 5713 Belair Date signed 12-25-47

VS 180

G58345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 A

Registered No. G58345

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 E. Sharp St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Eastern St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benny Mack

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Sumter S C
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Sumter Mack
13. Birthplace S C

MOTHER
14. Maiden Name Rosie Harrington
15. Birthplace S C

16 (a) Informant Samuel J. Mack
(b) Address 608 Eastern Street

17 (a) Removal (b) Date thereof 12-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sumter
Location South Carolina

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 1040 W Montgomery St

19 DEC 26 1947 (b) Huntington Williams, M.E.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21 1947, at 6:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dept Gelbrinka M.D.
Medical Examiner.
Date signed 12/21/47

058346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 058346

100C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 Bridgeview Road 1st fl.
(c) Hospital or institution:
Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 Bridgeview Road #1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Roberts.

3 (b) If veteran, name war
3 (c) Social Security Account No. 214-03-4738

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife Elizabeth [redacted]
Common-law wife only. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1895

8. AGE: Years	Months	Days	If less than one day
52 yrs	10	7	hr. min.

9. Birthplace Trappe, Eastern Shore
(Town, county, and state)
10. Usual Occupation Truck Driver.
11. Industry or business

FATHER
12. Name Robert R. Roberts
13. Birthplace Md.

MOTHER
14. Maiden Name Alice [redacted] Hopkins
15. Birthplace Md.

16 (a) Informant Elizabeth Gibson
(b) Address 303 Bridgeview Road 1st Fl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-47 (month) (day) (year)
(c) Cemetery or crematory Trappe Md.
Location Eastern Shore Md.
18 (a) Funeral director George S. Nelson
(b) Address 1303 Pressstman St.
19 (a) DEC 26 1947 (Date rec'd by registrar) (b) Huntington Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 22 1947 at 10:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 PM 12-2 1947 to 12-22 1947, and that I last saw him alive on 12-22 1947.

Immediate cause of death Pulmonary Congestion — Duration 15 Minutes

Due to Pulmonary Embolism

Due to

Other Conditions Phlebitis of Left leg.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerry G. Truck M. D.
Address 303 Bridgeview Rd Date signed 12/22/47

VS 150

111A

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94A

Registered No. 658347

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Winston Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Maempel

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen Sugmon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 6 1890

8. AGE: Years: 50 | Months: 5 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Laborer
11. Industry or business: St. Rail Co

FATHER
12. Name: Louis Maempel
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Katherine Bensdip
15. Birthplace: Baltimore Md

16 (a) Informant: Helen S. Maempel
(b) Address: 313 Winston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/29/47 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore Md

18 (a) Funeral director: Wilson & Dye
(b) Address: 1317 E Pratt St

19 (a) DEC 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1947 at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to h is death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: C. S. Subrinsky M.D.
Medical Examiner.
Date signed 12/27/47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 468

Registered No. 658348

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LINDEN AVE. AND MADISON ST.
(c) Hospital or institution:
MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 CHESTNUT HILL AVE (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN G SNYDER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of ~~husband or~~ wife FANNY L. SNYDER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 9TH 1898

8. AGE: Years	Months	Days	If less than one day
49	11	14	hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation MAINTENANCE
11. Industry or busines City of Balto

FATHER
12. Name HENRY SNYDER
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name Sarah Murray
15. Birthplace Va.

16 (a) Informant FANNY L SNYDER
(b) Address 506 CHESTNUT HILL AVE

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/26/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) DEC 26 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1947, at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 12/23 1947, and that I last saw him alive on 12/23 1947

Immediate cause of death	Duration
DEBILITY	
Due to CARCINOMATOSIS	
Due to CARCINOMA OF STOMACH	
Other Conditions ~~METASTATIC CARC.~~ FROM STOMACH NONE	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: METASTATIC CARC. FROM STOMACH
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide NONE
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul G. Herold M. D.
Address Md. Gen. Hospital Date signed 12/23/47

VS 150

Huntington Williams, M.D.

G58349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47A

Registered No. G58349

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Lansing Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Lansing Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis C. Warren

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17 1877

8. AGE: Years	Months	Days	If less than one day
70	4	11	hr. min.

9. Birthplace Nevis Hamilton N. H. (Town, county, and state)
10. Usual Occupation Clerk (Asst Treasurer)
11. Industry or business Commercial Credit

FATHER
12. Name Louis Warren
13. Birthplace N. H.

MOTHER
14. Maiden Name Mary Ann
15. Birthplace Mass

16 (a) Informant Frances V Warren
(b) Address 1714 Lansing Ave

17 (a) Dec 26 47 (b) Date thereof (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Wellington Coop Inc
(b) Address 1817 St Paul St

19 (a) DEC 26 1947 (Date rec'd by registrar) (b) Interment Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23, 1947, at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20, 1947, to Dec 23, 1947 and that I last saw him alive on Dec. 22 1947

Immediate cause of death	Duration
Carcinoma of Larynx	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Weiss M.D. M. D.
Address 1927 E. North Ave Date signed 12-24-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 F

Registered No. 658350

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto - 31
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Abingdon (Aberdeen)
(If outside city or town limits, write RURAL and give town)
(d) Street No. none given (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Willie May Stein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mr. Luther Stein

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 3-28-18

8. AGE: Years 29 | Months 8 | Days 27 | ~~If less than one day~~ hr. min.

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business at home

FATHER
12. Name George Wm Blocker
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Cassie Beatrice
15. Birthplace S. Carolina

16 (a) Informant Sister-in-law Mrs. Ida Stein

(b) Address R.F.D. 309 - Holly Grove - Oak Grove Church Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27 1947 (month) (day) (year)

(c) Cemetery or crematory Bakers

Location Aberdeen, Md.

18 (a) Funeral director H. K. McComas & Son

(b) Address Abingdon, Md.

19 (a) ~~DEC 26 1947~~ (Date received by local registrar) (b) Huntington Hattersville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Dec. 1947, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25- 1947 to 12-23 1947 and that I last saw her alive on 12-23 - 1947

Immediate cause of death Hemorrhage

Due to Carcinoma Primary Uterus vaginal

Due to Carcinoma of Throat

Other Conditions tracheotomy

(Include pregnancy within 3 months of death)

Date of operation 29 Nov. 1947

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D. Fischer M. D.

Address Church Home & Hosp. Date signed 12-24-47

VS 150

X

G58351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G58351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED: Baltimore
(a) State Md (b) County Middle River
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Tapi-way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin a. Lowrey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-17-44

8. AGE: Years	Months	Days	If less than one day
3	6	8/6	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Calvin Lowrey
13. Birthplace Md.

MOTHER
14. Maiden Name Fredericka
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Road
18 (a) Funeral director Leland L. Fisher
(b) Address 2112 Dundalk Ave.
19 DEC 26 1941 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Dec 23 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1947 to Dec 23 1947 and that I last saw him alive on Dec 23 1947

Immediate cause of death	Duration
Pulmonary Edema	3 days
due to	
Due to Uremia	
Due to Chronic Glomerulo-nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Spencer M.D.
Address Johns Hopkins Hosp Date signed 12-23-47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658352

658352

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Madison Apt. Hotel
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE S. LEWENBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Jacob Lewenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1869

8. AGE: Years	Months	Days	If less than one day
78	4		hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name I. Strauss
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. J. Lewenberg.
(b) Address Madison Apt.

17 (a) Burial (b) Date thereof 12/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonneborn & Son
(b) Address 902 Eutaw Place

19 (a) DEC 26 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24/1947 at 8:47 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21 1947 to 12/24 1947, and that I last saw HER alive on 12/24 1947

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 4 days
Due to HYPERTENSION
Due to ARTERIOSCLEROSIS
Other Conditions HYPERTENSIVE CARDIO-VASCULAR DISEASE
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Lesser M. D.
Address Sinai Hospital Date signed 12/26/47

VS 150

83A

G58353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G58353
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7008 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7008 Park Heights
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence D. Wilson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13 1893

8. AGE: Years 54 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Herman Hennenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Ernestine [illegible]
15. Birthplace Germany

16 (a) Informant Mr. Wm. Wilson
(b) Address 7008 Pk. Hgts.

17 (a) Burial (b) Date thereof 12/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon
Location Balt. Md.

18 (a) Funeral director Harris Sonderman
(b) Address 1902 Eutaw Pl.

19 (a) DEC 29 1947 (b) Curtis Fox Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1947 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 1947 and that I last saw h[illegible] alive on 12/25 1947

Immediate cause of death Pulmonary Edema — Duration 4 hrs

Due to Coronary occlusion — 5 hrs

Due to Coronary artery disease

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fannie Wilson M.D.
Address 524 York Rd Towson Date signed 12/29/47

VS 150

94A

File G58354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G58354

Over

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts
(c) Hospital or institution: Union Mem. Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 56 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 5400 BLK. LINDENWOOD ROAD (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT SLOMAN (Herbert Sloman)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M S (Wife)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1891

8. AGE: Years 56 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation SALESMAN

11. Industry or business

FATHER
12. Name HARRY SLOMAN
13. Birthplace PHILADELPHIA, PA.

MOTHER
14. Maiden Name BETTY WERNER
15. Birthplace BALTIMORE, MD

16 (a) Informant MRS. SERENA SLOMAN
(b) Address 5400 Greenspring Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ohel Shalom
Location Balto. Md.

18 (a) Funeral director Claude Sandelman & Son
(b) Address 1902 Eutaw Place, Baltimore, Md.

DEC 26 1947 (Date rec'd by registrar) (b) Twenty-four hours Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1947 at 6:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1947 to Dec 25 1947 and that I last saw h/its alive on Dec 24 1947.

Immediate cause of death Respiratory arrest. — Duration: over

Due to generalized toxemia

Due to Carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec. 11, 1947

Major findings of operation: GENERALIZED CARCINOMATOSIS - ADHESIONS

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Heryon Jr. M. D.
Address Union Mem. Hosp. Date signed 12-28-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G58355

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ——
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4513 Roland Ave
(If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country ——

3 (a) FULL NAME Edward Henry Kloppel

3 (b) If veteran, name war No

3 (c) Social Security Account No. NONE

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary Elizabeth

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 5, 1868

8. AGE: Years	Months	Days	If less than one day
79	5	18	—hr. —min.

9. Birthplace Baltimore Maryland (Town, county, and State)

10. Usual Occupation (Retired)

11. Industry or business —

FATHER
12. Name Herman Kloppel
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Wattenscheidt
15. Birthplace Germany

16 (a) Informant Mrs Lillian Kloppel (daughter)
(b) Address 4513 Roland Ave Balto-10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 26 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1947, at 5:17 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1947 to Dec 23 1947 and that I last saw him alive on Dec. 22 1947.

Immediate cause of death Intestinal Obstruction — Duration 3 days

Due to Carcinomatosis

Due to Carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec. 20, 1947

Major findings of operation: Carcinomatosis

of autopsy: Carcinoma of stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James McC. Finney M. D.
Address Union Memorial Hospital Date signed 12-22-47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~58356~~ 1st Dist.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 1278

Registered No. ~~58356~~ 058356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 68yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [illegible]
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Spring Grove Hospital 2238 Madeira St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Sokolsky or Ida Lester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 1879

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Lutheranie Lithuania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jack Sandler or Jack Pandler
13. Birthplace Lutheranie Lithuania

MOTHER 14. Maiden Name not known
15. Birthplace Lutheranie Lithuania

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-47 (month) (day) (year)

(c) Cemetery or crematory
Location Shrine of Mt. Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) DEC 26 1947 (Date rec'd by registrar) Thurston for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25 1947, at 8PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24- 1947 to 12-25 1947, and that I last saw her alive on 12-25- 1947.

	Duration
Immediate cause of death Cardiac respiratory failure	hrs
Due to bronchial pneumonia	36 hrs
Due to emphysema of gall bladder	72 hrs
Other Conditions diabetes, obstruction	24 hrs

(Include pregnancy within 3 months of death)
Date of operation 12/25/47
Major findings of operation Emphysema of gall bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt. City Hosps Date signed 12/25/47

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109

Registered 658357

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3517 Lucille Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Dol Cohen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Naomi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Poland

MOTHER
14. Maiden Name Freyda
15. Birthplace Poland

16 (a) Informant Naomi Cohen
(b) Address 3517 Lucille Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-47 (month) (day) (year)
(c) Cemetery or crematory Har Israel
Location Northern Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Place

19 (a) DEC 26 1947 (Date rec'd by registrar) (b) Huntington Hill Cemetery, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1947 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1947 to 12/24 1947, and that I last saw him alive on 12/24 1947.

Immediate cause of death Pulmonary edema
Pneumonia.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pneumonia - Pulm edema

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Norman Mann M.D.
Address Sinai Hosp Date signed 12/25/47

VS 150

C58358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106B

Registered No. C58358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 N. Chapel St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Wentker

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Bernard J. Wentker
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1884

8. AGE: Years	Months	Days	If less than one day
53	11	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Zech
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Kunigunda Schrenott
15. Birthplace Baltimore Md.

16 (a) Informant Bernard J. Wentker
(b) Address 11 N. Chapel St.

17 (a) Burial (b) Date thereof 12/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director The Dippel Brothers
(b) Address Lombard & Ann Sts.

DEC 26 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1947, at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1947, to 12/24 1947, and that I last saw h[illegible] alive on 12/23 1947.

Immediate cause of death	Duration
Secondary to Pontocaine -	
with resultant death	
Due to Fracture of Middle third	
of Patella & Hemarthrosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Hemarthrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 12/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D ✓

Registered No. C58359

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1430 Hollbrook St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Hollbrook St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Loretta le. le Clarkson

3 (b) If veteran, name war
3 (c) Social Security Account No. 216-10-7655

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 31st 1891

8. AGE: Years 56 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER 12. Name George J Obert

13. Birthplace Md

MOTHER 14. Maiden Name Mary Street

15. Birthplace Md

16 (a) Informant Thomas N. le Clarkson

(b) Address 1439 Hollbrook St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Leo G. Brook

(b) Address 1703 N. Patterson Park Ave

19 DEC 26 1947 (Date rec'd by registrar) Interpreter Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1947, at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10, 1938, to Dec 23 1947, and that I last saw her alive on Dec. 12, 1947

Immediate cause of death	Duration
Acute Cardiac Failure	6 hours
Due to Cardio-Vascular Hypertensive Disease	9 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Dausch M.D.

Address 1 W. Averlea Ave Date signed 12/23/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G58360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W 101 W. Cold Spring La.
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 S. Bond St. (If rural give location) 3-1 one
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry Terry

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Jan 6th 1869
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-1869

8. AGE: Years	Months	Days	If less than one day
78	11	15	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Records Cold Spring Nursing Home
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27, 47 (month) (day) (year)
(c) Cemetery or crematory Glenn Haven
Location St Paul + Preston, Balto, Md

18 (a) Funeral director Hartman Cook Hall
(b) Address 1717 St. Paul St

19 (a) DEC 26 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1947, at 10th M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947, to Dec 24 1947, and that I last saw h(im) alive on 12/24 1947.

Immediate cause of death	Duration
CORONARY ARTERIAL OCCLUSION	2 hrs.
Due to GENERALIZED ARTERIOSCLEROSIS	15 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Herman M. D.
Address 2803 Edmondson Ave Date signed 12/23/47

VS 150

58361 Dr Sandy 5106 Harford Rd Jan 2028 ✓ Registered No. 58361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 99

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Kayford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 W. 37th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah N. Neighoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~ widowed, or ~~divorced~~ Widowed

6 (b) Name of husband Edward Lee Neighoff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21st 1866

8. AGE: Years 81 | Months 2 | Days 3 | If less than one day ....hr. ....min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name John Hamilton

13. Birthplace Ireland

MOTHER 14. Maiden Name Sarah Crawford

15. Birthplace Unknown

16 (a) Informant Frank Neighoff

(b) Address 432 E. 37th St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/27/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ St. Marys

Location Hampden

18 (a) Funeral director Williams Cook Inc

(b) Address 1217 St. Paul St.

19 (a) DEC 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24th 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1947 to Dec 24 1947 and that I last saw h[illegible] alive on Dec 23 1947

Immediate cause of death	Duration
Gangrene of Right Foot	6 Weeks
Due to Cardiosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No.
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury None

23. Signature H. N. Crosby M.D.

Address 5106 Harford Rd Date signed 12/26/47 M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58362 — BALTIMORE CITY HEALTH DEPARTMENT — G58362

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 53rd Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Texas (If outside city or town limits, write RURAL and give town)
(d) Street No. Beaver Dam Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr Lawrence H. Burton

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Edna L. Burton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26, 1876

8. AGE: Years 71 | Months 9 | Days 29 | If less than one day: hr. min.

9. Birthplace: Baltimore, Co. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business: Quarry Owner

FATHER
12. Name: Thomas W. Burton
13. Birthplace: Baltimore, Co. Md.

MOTHER
14. Maiden Name: Emily Hillen Bull
15. Birthplace: Baltimore, Co. Md.

16 (a) Informant: Mrs. Edna L. Burton
(b) Address: Texas, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29 1947 (month) (day) (year)
(c) Cemetery or crematory: Waugh Church
Location: Greenwood, Md

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pennsylvania Aves

19 (c) DEC 26 1947 (Date rec'd by registrar) Arthur Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1947 at 10 22 M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 24 1947 to Dec 25 1947 and that I last saw him alive on Dec 25 1947.

Immediate cause of death: Massive Atelectasis Right Lung — Duration: 2 days
Due to:
Due to:
Other Conditions: Hypertensive card. 3 yrs. Hypertension visible, decompensated
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Massive Atelectasis

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: A. Ward Allen M. D.
Address: Union Mem Hosp Date signed 12-29-47

114-E

G58363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G58363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 CALVERTON HEIGHTS AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 CALVERTON HEIGHTS AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME U. S. GRANT HARDEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife CORRILLA E. nee CARSON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 3, 1867

8. AGE: Years	Months	Days	If less than one day
80	2	20	hr. min.

9. Birthplace CARROLL Co. MD
(Town, county, and state)
10. Usual Occupation RETIRED POLICEMAN
11. Industry or business City

FATHER
12. Name MR LEWIS HARDEN
13. Birthplace CARROLL Co. MD.

MOTHER
14. Maiden Name MARY ROBERTS
15. Birthplace ENGLAND

16 (a) Informant MR. HARRY M. GREISZ
(b) Address 2430 CALVERTON HEIGHTS

17 (a) BURIAL (b) Date thereof 12/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ MT. PLEASANT CEM.
Location CARROLL COUNTY, MD

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address LIGHT & PRATT AVES, BALTO. MD.

19 DEC 26 1947 (b) Lentington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 23 1947, at 9 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1947, to Dec 23 1947, and that I last saw h~~im~~ alive on Dec 23 1947.

	Duration
Immediate cause of death: Cerebral hemorrhage -	16 hours
Due to: Hypertension	10 years
Due to: Arteriosclerosis	25 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel J Schwartz M. D.
Address 2820 Eutaw Place Date signed 12/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G58364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58364

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 543 Birmingham Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Manila H. Richards

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	married

6 (b) Name of husband or wife Vernon Richards
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1898

8. AGE: Years	Months	Days	If less than one day
49	6	5	hr. min.

9. Birthplace Pennsylvania Johnstown (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Luther Davis
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Anna Murphy
15. Birthplace Pennsylvania

16 (a) Informant Husband
(b) Address 543 Birmingham

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)
(c) Cemetery Saters Cemt.
Location Balto. Co.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. aves. Balto. 17, Md.

19 (a) DEC 26 1947 (Date received by registrar) (b) Lester Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1947, at 3 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1947, to Dec. 25 1947, and that I last saw h alive on Dec. 25 1947.

Immediate cause of death	Duration
Uremia	
Due to Carcinoma of Cervix	
Due to	
Other Conditions Bilateral hydronephrosis Carcinoma metastasis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature K. L. Stone M. D.
Address University Hosp. Date signed 12-25-47

X

G58365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 A

Registered No. G58365

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Losp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltim ore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Rosedale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HENRY REED

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-09-6545

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Beatrice Reed
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1901

8. AGE: Years	Months	Days	If less than one day
46	7	22	hr. min.

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Reed
13. Birthplace Pa

MOTHER
14. Maiden Name Elizabath Dievert
15. Birthplace Pa.

16 (a) Informant Mrs. Beatrice Read
(b) Address 917 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/47 (month) (day) (year)
(c) Cemetery Western Mem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) DEC 26 1947 (Date received by Registrar) (b) Evelyn Hollingsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24, 1947 at 3:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1947 to 12/24 1947 and that I last saw h. alive on 12/24 1947.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration
Due to HYPERTENSION AND ARTERIOSCLEROSIS
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Garbutt M.D.
Address West Balto. 6 en Hosp. Date signed 12/26/47

VS 150

X

G58366 A-3 Dr Faulkner

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52B

Registered No. 43913 G58366

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 51 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore County
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Washington St (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Grace B. Priebe

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-24-7929

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Henry Priebe
6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.) 11-26-95

8. AGE: Years: 52 years | Months: 0 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Home
11. Industry or business:

FATHER
12. Name: John Brown
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Annie Hundley
15. Birthplace: Virginia

16 (a) Informant: Mr. Henry Priebe
(b) Address: 4005 Washington St. (JOHNS HOPKINS HOSPITAL)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Pk. Cem.
Location: Baltimore, Maryland

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: North & Pa. Aves. Balto. 17, Md.

19 DEC 26 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1947, at 1:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1947, to 12-25 1947, and that I last saw her alive on Dec 25 1947

Immediate cause of death	Duration
Pulmonary oedema	
Due to Heart failure	
Due to	
Other Conditions Carcinoma of bladder with stricture	

(Include pregnancy within 3 months of death)
Date of operation December 3, 1945
Major findings of operation: Carcinoma, epidermoid, bladder, infiltrating
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert J. Faulconer
Address Johns Hopkins Hosp. Date signed 12/29/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58367

LW 109618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. C58367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Cornish or(Mary E. Cornish)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24- 1925

8. AGE: Years 22 Months 5 Days 29 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Wallace
13. Birthplace ?

MOTHER
14. Maiden Name Ella Cornish
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof? Dec. 27-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 DEC 26 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23 1947, at 2:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2- 1947 to 12-23- 1947, and that I last saw her alive on 12-23 1947

Immediate cause of death: Pulmonary Tuberculosis
Duration: Acute & Ulcerative

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

29. Signature William H. Hunter M.D.
Address Balt City Hosp Date signed 31 Dec 47

X

658368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658368

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered. Use figures for dates. Do not abbreviate. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 MOS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Tenn. (b) County
(c) City or town Nashville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Joseph Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No. 251-12-0608

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/17/1900

8. AGE: Years	Months	Days	If less than one day
47	5	3	hr. min.

9. Birthplace Nashville, Tenn.
(Town, county, and state)
10. Usual Occupation Fireman Water Tender
11. Industry or business Merchant Seaman

FATHER
12. Name Oscar Taylor
13. Birthplace Nashville, Tenn.

MOTHER
14. Maiden Name Lillian Wright Taylor
15 Birthplace Nashville, Tenn.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-47 (month) (day) (year)
(c) Cemetery or crematory St Matthias
Location 08Donnell Street

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S.Wolfe Street

19 (a) DEC 26 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1947, at 11.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4, 1947 to Dec. 20, 1947 and that I last saw him alive on Dec. 20, 1947

Immediate cause of death	Duration
Squamous cell carcinoma of lower lip with metastasis to Peritoneum, messentery	4 Yrs.
Due to liver and spleen	
OTHER CAUSES	
Due to Cirrhosis of liver	Unknown
Coronary sclerosis	Unknown

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed
US Marine Hospital, Balto., Md.

VS 150

658369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. 658369

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 S. Lakewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD A. STANTON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Praydis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1900

8. AGE: Years	Months	Days	If less than one day
47	7	4	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Ship Yard

FATHER
12. Name James Stanton
13. Birthplace ?

MOTHER
14. Maiden Name Sophia Swoboda
15. Birthplace Czeck.

16 (a) Informant Mary Stanton
(b) Address 620 S. Lakewood Ave.

17 (a) Burial (b) Date thereof 12 27 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 6900 Eastern Ave.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe St. (31)

19 (a) DEC 26 1947 (b) Huntington Mitchellville

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24, 1947, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 12/16 1947 to 12/24 1947 and that I last saw h. alive on 12/22 1947.

Immediate cause of death Carcinoma stomach — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Lowery M.D.
Address 441 N. Ellwood Av. Date signed 12/26/47

X

G58370

JL - 116040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127C

G58370 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5008 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1889

8. AGE: Years 58 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-1947 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe Street

1947 DEC 26 (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1947, at 2.50pm

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1947 to Dec. 25 1947, and that I last saw him alive on Dec. 25 1947.

Immediate cause of death Cardio-vas - pulmonary Tamponade c Hemorrhage-pneumonia — Duration: Hrs

Due to ASCVD — Duration: yrs.

Due to — Duration:

Other Conditions Hyperplastic Prostate Due to Ruptured Bladder (Include pregnancy within 3 months of death) — Duration: 5 days

Date of operation 12/20/47

Major findings of operation: perforated bladder

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Bal. City Hosps Date signed 12/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658371

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) All yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 N Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anthony Di Filippo

3 (b) If veteran, name war: no.
3 (c) Social Security Account No. 216-65-0619

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Rose DiFilippo (nee Lanciapri)
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1877

8. AGE: Years	Months	Days	If less than one day
70	10	20	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Philip Di Filippo
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Rose DiFilippo
(b) Address 717 N. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/1947 (month) (day) (year)
(c) Cemetery or [illegible] Holy Redeemer
Location 4430 Belair Road, Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 DEC 26 1947 (Date rec'd by registrar) (b) [signature] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1947 at 9 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1947 to 12/23 1947 and that I last saw h/m alive on 12/23 1947

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May M.D.
Address 1400 N. Carline St Date signed 12/23/47

X

~~G58372~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58372

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2728 N. Charles ST
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs 10mos

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 BERWYN AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME William DANIEL Bush

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife MARY CATHERINE Bush
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 18, 1869

8. AGE: Years	Months	Days	If less than one day
78	1	8	— hr. — min.

9. Birthplace SANDYMOUNT, CARROL, MARYLAND (Town, county, and state)
10. Usual Occupation FARMER (Retired)
11. Industry or business OWN FARM

FATHER
12. Name William Bush
13. Birthplace SANDYMOUNT, CARROL, MARYLAND

MOTHER
14. Maiden Name MARGARET MILLER
15. Birthplace SANDYMOUNT, CARROL, MARYLAND

16 (a) Informant MRS. GRACE WEISS
(b) Address 3500 BERWYN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 1947 (month) (day) (year)
(c) Cemetery or crematory Providence, Cem'
Location Gamber Md.

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Hunting Washington / Williams, Hyde

19 (a) DEC 26 1941 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1947 at 9.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1947 to Dec. 26 1947 and that I last saw h/M alive on Dec 25 1947

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Auricular Fibrillation	4 hrs/days
Due to	
Other Conditions Bronch-pneumonia, Intestinal Carcinoma, (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melvin M. Borden M. D.
Address 203 W. Fayette St Date signed 12/24/47

95A

658373 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 658373

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Harney St. 21st Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Harry Thomas Crouse

If U. S. Veteran specify WAR

(a) Residence: No. 704 Harney St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M.	W	M

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Florence Shipley

6. DATE OF BIRTH (month, day, year) Sept. 14-1875

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	3 9	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore

FATHER

13. NAME Samuel F. Crouse

14. BIRTHPLACE (city or town) (State or country) Balto

MOTHER

15. MAIDEN NAME Eleanor Rafael

16. BIRTHPLACE (city or town) (State or country) Balto

17. INFORMANT Mrs. H. Roberts

(Address) Lemmon Rd

18. BURIAL, CREMATION, OR REMOVAL

Place Loudon Park Date 12/27/47

19. UNDERTAKER J. J. Sobey Home

(Address) 818 Light St

20. FILED DEC 26 1947 19 W. E. Williams Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 12-24, 1947

22. I HEREBY CERTIFY, That I attended deceased from 12-22, 1947 to 12-24, 1947

I last saw him alive on 12-24, 1947 Death is said to have occurred on the date stated above, at 10:00 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocardial Degeneration	
Other contributory causes of importance:	
Bronchopneumonia	2 days

Was an operation performed? Not Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) A. Ballard M. D.

(Address) 207 E. Fort Ave.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPATION is very important. See instructions on back of certificate.

V0 3

X

158374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. 158374

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Give correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 Athol Ave
(c) Hospital or institution: German Aged Peoples Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 Athol Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Blank

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife Herman Blank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1866

8. AGE: Years	Months	Days	If less than one day
81	—	3	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Geo. Klaus
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/47 (month) (day) (year)
(c) Cemetery or crematory St. Michaels
Location Govs Hall Md.

18 (a) Funeral director Donahue Funeral Home
(b) Address 7400 Belair Rd.

19 (Date rec'd by registrar) DEC 26 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25/47. 19 at 5 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10/47 to Dec. 25/47. and that I last saw h er alive on Dec. 23/47.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days.
Due to Arterio Sclerosis	Unknown.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harry Hecht Schmidt M. D.
Address 933 Hanover St. Date signed Dec 26/47.

VS 150

G58375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 948

Registered No. G58375

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 West Baltimore St.
(c) Hospital or institution: ////////////
(d) Length of stay in hospital or inst. (yrs., mos., or days) ////
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 West Baltimore Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. BRAUN

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-0135

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carrie J. Braun
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1892

8. AGE: Years	Months	Days	If less than one day
55	10	2	____ hr. ____ min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Tool Maker
11. Industry or business Westinghouse Electric

FATHER
12. Name Paul (August) R. Braun
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia H.
15. Birthplace Germany

16 (a) Informant Mrs. Carrie J. Braun
(b) Address 2513 West Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 Eutaw Place..17

19 (a) DEC 26 1947 (Date received by registrar) Registrar for Baltimore City

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23/ 1947, at ____ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1943 to Dec 23 1947, and that I last saw him alive on Dec 16 1947.

	Duration
Immediate cause of death Coronary thrombosis	1 hr.
Due to Arteriosclerotic coronary artery disease	8 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ____ M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Richard H. Tillman M.D.
Address 3035 St. Paul St. Date signed 12/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G58376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 89B

Registered No. G58376

Cal. 116054

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6115 O'Donnell ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George M Stewart.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27 1915

8. AGE: Years 32 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. MD. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Schwartzs Cemetery

FATHER
12. Name Cyrus Stewart
13. Birthplace Balto. MD.

MOTHER
14. Maiden Name Elizabeth Martin
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/47 (month) (day) (year)
(c) Cemetery or crematory Schwartzs
Location 6115 O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) Dec 26 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 - 1947 1947, at 9.15PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 - 1947 to Dec. 23- 1947, and that I last saw him alive on Dec. 23 - 1947

	Duration
Immediate cause of death respiratory failure	30 minutes.
Due to (1) regurgitation of vomitus	30 mins.
Due to	
Other Conditions part of mastoid-ectomy (Include pregnancy within 3 months of death)	hrs

Date of operation 12/23/47

Major findings of operation: cavity in mastoid process

of autopsy: cerebral edema & congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt. City Hosp. Date signed 12/28/47

V S 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inquired. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G58377 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Balto. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4353 Old Frederick Rd
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Clarence Shaeffer Schaeffer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mrs. Anna Shaffer
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JUNE 28, 1888

8. AGE: Years	Months	Days	If less than one day
59	5	26	..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Milton Schaeffer
13. Birthplace Md.

MOTHER
14. Maiden Name Minnie Hays
15. Birthplace Md.

16 (a) Informant Mrs ANNA SCHAEFFER
(b) Address 4353 OLD FREDERICK RD.

17 (a) BURIAL (b) Date thereof DEC. 29, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE MD.

18 (a) Funeral director Harry A Wright
(b) Address 4101 Edmondson Ave.

19 (a) DEC 26 1947 (b) Huntington Wills
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24/1947, at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22/1947 to 12/24/1947 and that I last saw h.. alive on 12/24/1947

Immediate cause of death	Duration
Cardiac failure	
Due to Acute Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Gordon Ewer M. D.
Address Mercy Balto Gen Hosp Date signed 12/27/47
For Dr. W. Ewer, by Howard J. Mallonee MD
X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (46)

Registered No. G58378

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 DELMONT AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 DELMONT AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HERMAN H. KINDT

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-6140 A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Sadie Kuhl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1873

8. AGE: Years	Months	Days	If less than one day
74	0	1	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation
11. Industry or business Rubber Millers Inc

FATHER
12. Name Wilhelm Kindt
13. Birthplace Germany

MOTHER
14. Maiden Name -
15. Birthplace Germany

16 (a) Informant Mrs Sadie Kindt
(b) Address 2803 Delmont Ave

17 (a) Burial (b) Date thereof Dec. 26 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location ANNAPOLIS BLVD - BROOKLYN

18 (a) Funeral director Harry H. Wilkes
(b) Address 4101 Edmondson Ave

19 (a) DEC 26 1947 (b) Huntington Williamson, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 1947 to DEC 23 1947, and that I last saw him alive on DEC 23 1947

Immediate cause of death	Duration
Carcinoma of Rectum	1 YR
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward A. Kallins M. D.
Address 1847 W. North Ave Date signed 12/23/47

VS 150

058379

BALTIMORE CITY HEALTH DEPARTMENT

Gosnell CERTIFICATE OF DEATH 93D

Registered No. 058379

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lemien + madison

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3710 Wilfred Ave
MILFORD (If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Bassett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband ~~or wife~~ Late Samuel T

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1871

8. AGE: Years	Months	Days	If less than one day
86	10	23rd	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis T Ford
13. Birthplace Germany

MOTHER
14. Maiden Name Leanna Bisor
15. Birthplace Md.

16 (a) Informant Mrs Leah Birkhead
(b) Address 3710 Milford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29/1947 (month) (day) (year)

(c) Cemetery or crematory London Park
Location 3201 Frederick Ave

18 (a) Funeral director Harry H Wittle
(b) Address 4101 Edmondson Ave

19 (a) DEC 26 1947 (Date filed by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1947, at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1947, to Dec. 24 1947, and that I last saw h~~e~~r alive on Dec. 23 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Hemorrhage	
Due to Hypertensive cardio vascular Disease	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Burkhart

Address Md. General Hospital Date signed 12/24/47 (M. D.)

VS 150

G58380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G58380 Registered No.

Every item of information should be carefully supplied. Use write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4401 Colborne Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lehr LEHR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of ~~husband~~ or wife: Margaret Kender

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 - 10 - 1870

8. AGE: Years 77 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name George Lehr
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Seibert
15. Birthplace Germany

16 (a) Informant Mrs. George Lehr
(b) Address 4401 Colborne Rd.

17 (a) Burial (b) Date thereof 12/27/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Frederick Rd.

18 (a) Funeral director Harry A. Fitzler
(b) Address 4101 Edmondson Ave.

19 (a) DEC 26 1947 (b) Waiting for Certificate
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24-1947 at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Laceration of brain Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-17-47 7:30 P.M.
(b) Where did injury occur? 12-17-47
(c) Did injury occur at home or on farm, industrial place, in public place? Garage While at work? Yes
(d) Means of injury Blunt force

23. Signature Howard J. Lucidi M.D.
Medical Examiner.
Date signed 12-25-47

G58381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D X

Registered No. G58381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 Taylor Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Rightmiller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Gladys J. Rightmiller
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Mar 5, 1895

8. AGE: Years	Months	Days	If less than one day
52	9	18	....hr. ....min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name John Rightmiller
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine Gruber
15. Birthplace Mt Cherry Lower Rd

16 (a) Informant Mrs. Gladys J. Rightmiller
(b) Address 2412 Taylor Ave

17 (a) Burial (b) Date thereof Dec. 27, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer H. Cookman & Son
(b) Address 924 E. Eager St.

19 (a) DEC 27 1947 (b) Huntington for Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1947, to 12/23 1947, and that I last saw h alive on 12/23 1947.

	Duration
Immediate cause of death Intracranial hemorrhage	11 hrs.
Due to Hypertensive Cardiovascular Disease	? Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry V. Chase M. D.
Address Mercy Hospital Date signed 12/30/47

X 4

658382

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

125 B

Registered No. 658382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto Co. Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~700 Monument St~~ 612 Dorsey Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Lowe

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Wilbur Lowe
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Lang
15 Birthplace Md

16 (a) Informant John W Lowe
(b) Address 612 Dorsey Ave Essex

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-26-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co.

18 (a) Funeral director [illegible]
(b) Address 1607 Eastern Ave Md

19 (a) [illegible] by Registrar) Huntington Williams M.D. Registrar

DEC 27 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24, 1947, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24, 1947 to Dec 24, 1947 and that I last saw him alive on Dec 24, 1947

Immediate cause of death Cardiac Failure — Duration

Due to

Due to

Other Conditions Hypoglycemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Necrosis of liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley H. Steinberg M
Address Sinai Hospital Date signed 12/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~58383~~ G58383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 480

Registered No. G58383

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 783 r Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 783 r Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine G. Lotman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harry I Lotman

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Feb 27 1887

8. AGE: Years	Months	Days	If less than one day
60	10	27	hr. min.

9. Birthplace New Orleans La.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Williams Hood
13. Birthplace U.S.

MOTHER
14. Maiden Name Mary Hickman
15. Birthplace U.S.

16 (a) Informant Harry Lotman
(b) Address 783 r Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 1947 (month) (day) (year)
(c) Cemetery or crematory Westerly Cem.
Location Baltimore Md.

18 (a) Funeral director E. Willis Lawrence
(b) Address 1510 Liberty Heights Ave

19 DEC 27 1947 (Date rec'd by Registrar) Authority for Williams M.D.

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27th 1947 at 3:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 12 1947 to Dec 27 1947, and that I last saw her alive on Dec 23 1947

Immediate cause of death — Duration

Carcinoma of Uterus — 6 mos

Due to Malignancy

Due to Cachexia — ✓

Other Conditions ✓

(Include pregnancy within 3 months of death)

Date of operation ✓

Major findings of operation ✓

of autopsy ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature John A. Hartwell M.D.
Address 1219 Eutaw Place Date signed 12/27/47

G58384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G58384

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 W. York St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13, 1913

8. AGE: Years	Months	Days	If less than one day
(35)34			hr. min.

9. Birthplace Washington DC
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER — 12. Name Benjamin? Williams

13. Birthplace ? Unknown

MOTHER — 14. Maiden Name Olga? Holmes

15. Birthplace Washington DC

16 (a) Informant Mrs Ethel Baltimore

(b) Address 927½ F St. S.W. Wash. D.C.

17 (a) Removal (b) Date thereof 12/26/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Washington, D. C.

18 (a) Funeral director Barnes & Matthews

(b) Address Washington, D. C.

19 (a) DEC 27 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1947, at 3.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of heart

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-24-47 at 11.20 P. M.
(b) Where did injury occur? 104 W. York St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stabbing- sharp instrument

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-25-47

C38385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82A

Registered No. C58385

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 MONTPELIER ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MRS. AGNES S. McKENNA (AGNUS McKENNA)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1 - 1889

8. AGE: Years	Months	Days	If less than one day
58	3	23	hr. min.

9. Birthplace Vt. (Town, county, and state)
10. Usual Occupation Nurses Home
11. Industry or business

FATHER 12. Name Sheahon
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Pk.
Location Balto

18 (a) Funeral director L. J. Lugk
(b) Address 5305 Harford Rd

19 DEC 27 1947 (Date rec'd by registrar) by Arlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1947 at 9 AM 25

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1947 to 12/24 1947. and that I last saw her alive on 12/24 1947

Immediate cause of death CEREBRAL HEMORRHAGE — Duration

Due to HYPERTENSION, ESSENTIAL

Due to

Other Conditions ARTERIOSCLEROSIS GENERAL

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Hourahan M. D.
Address St. Jos. Hosp. Date signed 12/27/47

V S 150

G58386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 176

Registered No. G58386

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 N. Wolfe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1920

8. AGE: Years	Months	Days	If less than one day
27	11	3	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Sandy Brown
13. Birthplace Va

MOTHER
14. Maiden Name Ella Wheeler
15. Birthplace Va.

16 (a) Informant Margaret Brown
(b) Address 1115 N Wolfe St

17 (a) Removal (b) Date thereof Dec 27/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Dellwyn Va

18 (a) Funeral director Wm Rost & Elliott Dept
(b) Address 1129 N. Caroline St.

19 (a) DEC 24 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 19 47 at 6:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Respiratory failure

Due to collapse of left lung

Other Conditions Amputation of left upper extremity; Fracture of 1 & 2 ribs, left
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26-4

(a) Date of injury 12-23-47 at 11:00 A.M.

(b) Where did injury occur? V. Taturzo Block Company 800 Blk. N. Heaven St.

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury Caught in cement mixer

23. Signature [signature] M.D.
Medical Examiner.

Date signed 12-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

658387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. 658387

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 W 24th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 W. 24th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Walls

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife, Catherine Walls
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24th 1866

8. AGE: Years 81 | Months 74 | Days 1 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Retired Farmer

11. Industry or business

FATHER
12. Name Charlie Walls
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Maynard L. Walls
(b) Address 669 John St

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof Dec 29th 19[illegible] (month) (day) (year)
(c) Cemetery or crematory Mt Helena Cem
Location Winchester Va.

18 (a) Funeral director B. E. Hartle
(b) Address 121 E. Wash St

19 DEC 27 1947 (Date filed by Registrar) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24/47 19 at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/30/47 19 to 12/24 19 47 and that I last saw h[illegible] alive on 12/24/47.

Immediate cause of death	Duration
Acute Myocardite	
Due to Endocarditis	
Due to Arteriosclerosis	
Other Conditions Results	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm J. Gordon M. D.
Address 612 Edmondson Date signed 12/26/47

VS 150

G58388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193A

Registered No. G58388

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 658 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wormley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	colored	Single

6 (b) Name of husband or wife 3-11-1866

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
81	9	12	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Wormley
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Coleman
15. Birthplace Va.

16 (a) Informant Edward Wormley New Haven
(b) Address 218 Monson St. Conn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-47 (month) (day) (year)

(c) Cemetery or crematory Fredericksburg
Location Fredericksburg Va

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Leigh Hill

19 (a) DEC 27 1947 (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1947, at 5:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1947 to Dec 23 1947, and that I last saw h. alive on Dec 23 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Hypostatic pneumonia	
Due to	
Other Conditions Cerebral Vascular Accident	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. C. Duvall Jr. M. D.
Address University Hosp. Date signed Dec 23

C58389 MARQUETTE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C58389

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 Venable Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 Venable Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma E Marquette

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife James Marquette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1881

8. AGE: Years 65 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W. Shaw
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sidney Lamy
15. Birthplace Baltimore Md

16 (a) Informant James Marquette
(b) Address 803 Venable Ave

17 (a) Burial (b) Date thereof 12/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Coffey
(b) Address 1219 E Cold St

19 (a) DEC 27 1947 (b) Arthur Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1947, to 12-24 1947, and that I last saw her alive on 12-24 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. K. Cusack Jr. M. D.
Address 36 York Ct Date signed 12-26-47

VS 150

X

G58390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124A

Registered No. G58390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Dr. and 31st St.
(c) Hospital or institution:
US Marine Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Aubrey Thomas Wainwright

3 (b) If veteran, name war	3 (c) Social Security Account No.
W W 2	216-10-8199

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Violet Gordon Wainwright
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) August 9, 1901

8. AGE: Years	Months	Days	If less than one day
46	4	16	hr. min.

9. Birthplace Matthews Co., Va.
(Town, county, and state)
10. Usual Occupation Mightmate (seaman)
11. Industry or business Merchant Seaman

FATHER
12. Name George Wainwright
13. Birthplace Eastern Shore Md.

MOTHER
14. Maiden Name Pauline Hudgins
15 Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 12/27/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) DEC 27 1947 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1947, at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17, 1947, to Dec. 25, 1947, and that I last saw him alive on Dec. 25, 1947.

Immediate cause of death	Duration
Hemorrhage from ruptured esophageal varices	2½ MOS.
CONTRIBUTING CAUSE;	
(a) Laennec's Cirrhosis	Unknown
(b) Passive congestion of lower lobes of lung bilaterally	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
Address John L. Wilson, Senior Surgeon, Clinical Director Date signed 12/26/47

VS 189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

658391 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inquired. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 Caithness St
(c) Hospital or institution: Franklin Sq. Hosp 2nd
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cheono, Stuliano

3 (b) If veteran, name war —
3 (c) Social Security Account No. 7

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9 - 1883

8. AGE: Years	Months	Days	If less than one day
64	1	15	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Vincent Cheono (Son)
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-47 (month, day) (year)
(c) Cemetery or crematory New Catholic
Location Old Frederick Rd

18 (a) Funeral director Joseph Casuskas
(b) Address 602 Washington Blvd

19 (a) DEC 27 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 19 47 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22/ 19 47, to 12/24 19 47, and that I last saw him alive on 12/24 1947.

Immediate cause of death	Duration
Bronchial Pneumonia	
& Emphysema	
Due to	
Due to	
Other Conditions Arteriosclerotic heart disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence [redacted] at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address Joseph B Johnson M.D. Date signed 12-27-47 M. D.
Franklin Sq Hosp. 110A

G58392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58392 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3710 Yolanda Road
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Yolanda Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Florence Lindsay Askew

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife William Robert Askew
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 25 1872

8. AGE: Years	Months	Days	If less than one day
75	1	29	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business On Home

FATHER 12. Name F. Willis Lindsay
13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary Thompson
15. Birthplace Baltimore

16 (a) Informant Miss Marie Askew
(b) Address 3710 Yolanda Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) DEC 27 (Date rec'd by registrar) (b) Interment Baltimore Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1947 at 7.58 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9- 1947 to Dec 24 1947 and that I last saw h. alive on Dec 23 1947

Immediate cause of death	Duration
Chr. Myocarditis	1938
Due to	
Due to Rheumatoid Arthritis	1938
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rance Brown M.D.
Address 1663 W Mount St Date signed 12/27/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 58393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 DUKER COURT
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 DUKER COURT (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA SZYMANSKI
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife ANTHONY
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name KAROL
13. Birthplace POLAND

MOTHER
14. Maiden Name JOSEPHINE SZCZLICKI
15. Birthplace POLAND

16 (a) Informant ANTHONY SZYMANSKI
(b) Address 2305 DUKER COURT

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 29-47 (month) (day) (year)
(c) Cemetery or crematory HOLY ROSARY
Location BALTIMORE

18 (a) Funeral director Fred W Oszczuski
(b) Address 1930 EASTERN AVE

19 (a) DEC 27 1947 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 25 1947, at 10:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1947 to Dec. 25 1947, and that I last saw her alive on Dec. 25 1947

Immediate cause of death Cardio vascular arterio-sclerosis with hypertension — Duration: years

Due to — Duration:

Due to — Duration:

Other Conditions Diabetes mellitus — Duration: 17 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sigmund R. Nowak M.D.
Address 408 S. Patterson Pk. Ave Date signed 12/26/47 M. D.

93D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 58394

58394 930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DUKELAND & RAYNOR AVES
(c) Hospital or institution: WEST BALTO. GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15/6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2041 BRADDISH AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARTIN VAN COLLOM

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-3856

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ETHEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Manager

FATHER
12. Name David Van Collom
13. Birthplace Phila Penna

MOTHER
14. Maiden Name Helen Pollock
15. Birthplace Balto Md

16 (a) Informant Ethel Van Collom
(b) Address 2041 Braddish Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12 28 47 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location 3600 E. BALTO. ST

18 (a) Funeral director SOL LEVINSON & BROS.
(b) Address 1124-26 W. NORTH AVE

19 (a) DEC 27 1947 (Date rec'd by registrar) (b) Justice & Williams, Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25, 1947 at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 25 1947 to DEC 25 1947 and that I last saw H.M. alive on DEC 25, 1947.

Immediate cause of death	Duration
CORONARY INSUFFICIENCY	
Due to CORONARY OCCLUSIONS, OLD, MYOCARDIAL FIBROSIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Rubenstein M. D.
Address West Balto. Gen. Hosp. Date signed 12/28/47

X

058395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

058395 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 Park Avenue
(c) Hospital or institution: Baltimore City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: VIOLA (MAURER

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): MAY 1, 1887

8. AGE: Years: 60 | Months: 7 | Days: 23 | If less than one day: hr. min.

9. Birthplace: BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation: CARPENTER

11. Industry or business

FATHER
12. Name: Marcellus Edwards
13. Birthplace: Northumberland Co., Va

MOTHER
14. Maiden Name: Blanche Downey
15. Birthplace: Maryland

16 (a) Informant: MRS VIOLA EDWARDS
(b) Address: 1046 PATAPSCO ST. - 30

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)
(c) Cemetery or crematory: LOUDUN PARK
Location: FREDERICK RD.

18 (a) Funeral director: JOHN F. DENNY, INC.
(b) Address: 715 LIGHT ST.

19 DEC 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24- 1947 at 2 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Mueller M.D.
Medical Examiner.
Date signed 12-24-47

658396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170 C

Registered No. 658396

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 44 Florida Avenue, N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES PHELPS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace Laurens, S.C. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Fuddie C. Phelps
13. Birthplace Laurens, S.C.

MOTHER
14. Maiden Name Pearl Adams
15. Birthplace Laurens, S.C.

16 (a) Informant Mrs. Pearl Phelps
(b) Address 44 Florida Ave., N.W. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/47 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington, Virginia

18 (a) Funeral director J. Bonsal Jones & Co
(b) Address 1432 Irving St. N.W.

19 (a) DEC 29 1947 (Date received by Registrar) (b) Washington, D.C. (Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1947, at 9 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Fracture of Head

Due to

Other Conditions Fract of Sternum & 4th rib left.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 53-00

(a) Date of injury 12-25-47 at 9 P. M.
(b) Where did injury occur? Wash. Blvd. front Halethorpe Police- Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Driver collision into bus

23. Signature Earl V. Boyer M.D. (Medical Examiner)
Date signed 12-26-47

C58397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 E

Registered No. C58397

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 M
(e) Length of stay in Baltimore (yrs., mos., or days) Life (44)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Dorn St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Sanders Gant

3 (b) If veteran, name war: Col
3 (c) Social Security Account No.: [illegible]

4. Sex: M
5. Color or race: 44
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 28-1903

8. AGE: Years 44 | Months 8 | Days 28 24 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Frank Gant Md
13. Birthplace

MOTHER 14. Maiden Name Jane ? Md
15. Birthplace

16 (a) Informant Hattie Cameron (friend)
(b) Address 1133 Dorn St.

17 (a) Burial (b) Date thereof 12-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location B. & O.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) DEC 27 1947 (b) Undertaker for Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/1947, at 9:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1947 to 12/23 1947 and that I last saw h.t.m alive on 12/23 1947.

	Duration
Immediate cause of death: Malnutrition & Starvation	8 mos
Due to: Malignancy of Colon	Unknown
Due to	
Other Conditions: Hypertension	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. W. Hoffler
Address Provident Hosp. Date signed 12/24/47

X

C68398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

C68398 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Barry Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Russell Ellsworth Allison

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-03-9110

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Evelyn M. Allison

6 (c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Oct. 19, 1907

8. AGE: Years: 40 Months: 2 Days: 8 If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business:

FATHER
12. Name: James T. Allison
13. Birthplace: Balt. Md.

MOTHER
14. Maiden Name: Laura Belle Owing
15. Birthplace: Balt. Md.

16 (a) Informant: Evelyn M. Allison
(b) Address: 708 Barry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 29 1947 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn, Md.

18 (a) Funeral director: C. Kenneth Donovan
(b) Address: 265-17 Chestnut Ave.

19 (a) DEC 27 1947 (Date filed by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1947, at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1947 to Dec 26 1947 and that I last saw him alive on Dec 26 1947.

Immediate cause of death: Tuberculous Meningitis — Duration: 7 hr

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 9-3-47

Major findings of operation: Tbc of Cauda Equina

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: H. C. Williams M. D.
Address: Date signed

VS 150

Kap X 12-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G58399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1305 Greenmount Ave.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK J. BOONE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Penelope M. Boone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown.

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Balto City Jail

FATHER
12. Name John W. Boone
13. Birthplace Md.

MOTHER
14. Maiden Name Rosie Bowman
15. Birthplace Md.

16 (a) Informant Francis E. Boone
(b) Address 321 E. 28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.

18 (a) Funeral director Kenneth R. Damaree
(b) Address 3615 12 Chestnut Ave.

19 (a) DEC 27 1947 (Date rec'd by registrar) (b) Livingston Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1947, at 8.25 A.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Date signed 12-26-47 Medical Examiner.

658400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658400

IN. 115938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 Powers St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27th 1894

8. AGE: Years	Months	Days	If less than one day
53	-	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Harry Miller (D
13. Birthplace Pa.

MOTHER
14. Maiden Name Carrie Hornberger
15. Birthplace Pa.

16 (a) Informant Baltimore, City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Wurzbach Mill Rd

18 (a) Funeral director L. Benquethe & Damascus
(b) Address 3615-17 Chestnut Ave.

19 (a) Dec 27 1947 (month) (day) (year) (b) Washington Hillsmere Md

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25th 1947 at 11.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16th 1947 to Dec. 25 1947 and that I last saw her alive on Dec. 25 1947

Immediate cause of death Sudden unexplained death

Due to ? Bronchogenic Carcinoma

Due to

Other Conditions Uraemia, mild Rt hemiparesis - ? metastatic
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Kuleny Jr. M.D.
Address Balto City Hosp Date signed 6 Dec 47

V S 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. 58401

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 133 S. Caroline St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 S. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert George Lawson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Naomi Lawson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1908

8. AGE: Years 39 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business

FATHER
12. Name John Lawson
13. Birthplace N.C.

MOTHER
14. Maiden Name Fannie Neil
15. Birthplace N.C.

16 (a) Informant Naomi Lawson
(b) Address 133 S. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn, Md.

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brantly Ave.

19 (a) DEC 27 1947 (Date rec'd by registrar) (b) Huntington Williams

Dec. 23 **MEDICAL CERTIFICATION** 3:10 PM

20. DATE OF DEATH 28 Dec 1947, at 3:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Dec 1947, to 23 Dec 1947, and that I last saw him alive on 22 Dec 1947

	Duration
Immediate cause of death: Coronary Cardiac dilitation	1 hr
Due to: Coronary Thrombosis	1 day
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Burrell M. D.
Address 1V1 Augusta Ave Date signed 12-27-47

VS 150

C58402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. C58402

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DONALD JUDY Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife (Mary) Jessel Judy

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Oct. 7th, 1884

8. AGE: Years	Months	Days	If less than one day
63 (55)	2	19	hr. min.

9. Birthplace Upperstract, W. Va
(Town, county, and state)

10. Usual Occupation CARPENTER

11. Industry or business Howard Bart. Const Co

FATHER
12. Name William H. Judy
13. Birthplace W. Va.

MOTHER
14. Maiden Name Barbara Helena
15. Birthplace W Va.

16 (a) Informant Nellie M Judy Wash D.C.
(b) Address 5012 N. Capitol St N W

17 (a) Removal (b) Date thereof 12/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union Memorial Cem. Bedford Co Pa
Location EVERETT, PA.

18 (a) Funeral director W. M. T. TICKNER & SONS INC
(b) Address North & Pa Ave Balto. Md.

19 (c) DEC 27 1947 by Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1947, at 11.55 P M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH CO poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-26-47 at 11 p. M.
(b) Where did injury occur? 535- N Fulton Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating gas

23. Signature [signature] M.D.
Medical Examiner
Date signed 12-27-47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC-47-9752

58403 Clotworthy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161A

Registered No. 58403

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Brooklandville, (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby boy Clotworthy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 20 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name C. Baker Clotworthy
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Frances Stinglieff
15. Birthplace Balto. Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27/47 (month) (day) (year)
(c) Cemetery or crematory Bew Cathedral
Location Balto Md

18 (a) Funeral director Henry N. Feldmeier & Son
(b) Address McCulloh & Richards

19 DEC 27 1947 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 - 1947 at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1947 to Dec 27 1947, and that I last saw h alive on Dec 27 1947

Immediate cause of death: Hemolytic Anemia of Newborn — Duration: 1 day
Due to: Erythroblastosis Fetalis
Due to:
Other Conditions: Atelectasis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Lovell Langsdorf M. D.
Address Johns Hopkins Hosp Date signed 12-27-47

658404
AF-116121

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 126

Registered No. 658404

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2hrs?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 E. Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Watkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?

8. AGE: Years	Months	Days	If less than one day
72?			hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem. Co.
Location A. A. County Md.

18 (a) Funeral director Wm. Gibbs McNeal Inc.
(b) Address 1124 N. Caroline St.

19 (a) DEC 27 1947 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Dec. 25- 1947, at 8.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25- 1947, to 12-25-47 1947, and that I last saw h. im alive on 12-25- 1947.

Immediate cause of death	Duration
Unexplained	
Due to	
Due to	
Other Conditions Stone in common duct c clinical icterus (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: As above	

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vanlear Jr. M.D.
Address Balto City Hosp Date signed 6 Dec 47

V S 150

X

G58405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G58405 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Renzo Townsend

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-22-26

8. AGE: Years 21 | Months 8 | Days 2 | If less than one day: hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Townsend
13. Birthplace N.C.

MOTHER
14. Maiden Name Sally Davis
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof Dec 27 1947
(month) (day) (year)
(c) Cemetery or crematory Wadesboro N.C.
Location

18 (a) Funeral director
(b) Address

19 (a) DEC 27 1947 (b) Huntington Williamsburg, Md.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1947, to Dec 24 1947, and that I last saw h.[illegible] alive on Dec 24 1947.

Immediate cause of death	Duration
UREMIA	? 2 WKS
Due to Chronic glomerulonephritis	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas E. Van Metre Jr. M. D.
Address Johns Hopkins Hospital Date signed Dec 27 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G58406 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Chamberlin
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 6, 1897
8. AGE: Years 50 Months 7 Days 17 If less than one day hr. min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business
FATHER 12. Name Elder Chamberlin
13. Birthplace Va.
MOTHER 14. Maiden Name Jannie Cotthorn
15. Birthplace Va.
16 (a) Informant Malcom Chamberlin
(b) Address 540 Baker St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Maryland
18 (a) Funeral director J. Bishop Rodstead
(b) Address 918 Druid Hill Ave.
DEC 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23 1947, at 8:30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 12/21/1947 to 12/24/1947 and that I last saw h[im] alive on 12/23/1947

Immediate cause of death	Duration
Uremia Bright's Disease	1yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. Bishop Rodstead, M.D.
Address 456 W. Biddle St. Date signed 12/26/47

Dr. Haase

G58407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G58407

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2820 Overland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 Overland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Catherine A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	13	14 hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John P. Hoffman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Busch
15. Birthplace Md.

16 (a) Informant Miss Marie Hoffman
(b) Address 2820 Overland Avenue.

17 (a) Burial (b) Date thereof 12-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 1

19 (a) Dec 27 1947 Received by Registrar [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1947, at 10:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Dec 1947, and that I last saw him alive on Oct. 1947

Immediate cause of death Coronary occlusion — Duration 5 min.

Due to Retrosternal pain C.V. Disease

Due to

Other Conditions Emphysema of lungs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Henry Haase, M.D.

Address 4218 Harford Rd. Date signed 12/29/47

D58408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. D58408

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Avenues
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME James Mc Philomy

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-14-1868

8. AGE: Years	Months	Days	If less than one day
79	7	14	hr. min.

9. Birthplace Phila. Pennsylvania
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name David John Mc Philomy
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Henrester
15. Birthplace Phila. Penna.

16 (a) Informant Seton Institute
(b) Address Reisterstown Road, City

17 (a) Burial (b) Date thereof Dec 30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Stewart & Mowing Company
(b) Address 102 W. North Ave, City

DEC 29 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1947, at 10:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26, 1947 to Dec. 28, 1947, and that I last saw him alive on Dec. 28, 1947.

Immediate cause of death	Duration
(a) Respiratory failure	
Due to (b) Pneumonia, pulmonary embolism	
Due to (c)	
Other Conditions Post operative inguinal hernia repair	

(Include pregnancy within 3 months of death)
Date of operation 12-27-47
Major findings of operation: large complete indirect inguinal hernia left
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A. Lumpkin M. D.
Address St. Agnes Hospital Date signed 12-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G58409 CERTIFICATE OF DEATH 166 G58409 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 W. Poyson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Simmons

3 (b) If veteran, name war: World War 2
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10. 1918

8. AGE: Years	Months	Days	If less than one day
29	3	14	hr. min.

9. Birthplace Forest Getty, N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business P.R.R.

FATHER
12. Name Walter Simmons
13. Birthplace N. C.

MOTHER
14. Maiden Name Elsie McIntosh
15. Birthplace N. C.

16 (a) Informant Mrs. Hettie Petty
(b) Address 210 N. Belnord St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-47 (month) (day) (year)
(c) Cemetery or crematory Dogwood Grove
Location Forest Getty, N. C.

18 (a) Funeral director William H. Jackson
(b) Address 916 Penna. Ave.,

19 (a) DEC 28 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24-1947 at 11 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture Skull with Intracranial Hemorrhage due to bullet

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-24-47 at 2 P.M.
(b) Where did injury occur? In alley at rear of 1600 block Pork St. West Fayette St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Homicide

23. Signature Howard J. Weldon M.D. Medical Examiner.
Date signed 12-25-47

VS 191

G58410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G58410 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 Evesham Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Evesham Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Friding er

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: John E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1872

8. AGE: Years	Months	Days	If less than one day
75	4	16	hr. min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alfred Henneberger
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Wample
15. Birthplace Pa.

16 (a) Informant Mrs. Milton A. Mundey
(b) Address 815 Evesham Ave.

17 (a) Burial (b) Date thereof 12/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosehill
Location Hagerstown Md.

18 (a) Funeral director Wm. J. TICHNER & SONS
(b) Address North & Pa. Aves

19 (a) 12 28 1947 (b) Hagerstown, Md.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/ 19 47, at 4.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17th. 19 47. to Dec. 26th 19 47, and that I last saw her alive on Dec. 26th. 19 47.

Immediate cause of death	Duration
Coronary Embolism	immediate
Due to Arteriosclerosis and Myocarditis	unknown
Due to ------	
Other Conditions Diabetes Mellitis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jno W Stonesifer M.D.
Address 401 E. 25th. St. Date signed 12/27/47.

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G58111 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2228 W. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Charles Edward Winkelman

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Minnie Winkelman
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1877

8. AGE: Years 70 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Foreman
11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Louis Winkelman
(b) Address 2100 Park Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-47 (month) (day) (year)
(c) Cemetery or crematory Sarasota Cemetery
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave. Baltimore (or Halethorpe), Md.

19 (a) Date received by registrar DEC 28 1947 (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1947, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Dec 1947 and that I last saw h.. alive on Dec 25 1947.

Immediate cause of death	Duration
Coronary Disease	2 wks.
Due to Arteriosclerotic C.V. Disease	8 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Lee Schlenker M.D.
Address 1945 W. Balto St. Date signed 12/30/47

X

G58412 BALTIMORE CITY HEALTH DEPARTMENT G58412
CERTIFICATE OF DEATH 469 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7126 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yr
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 7126 Park Heights Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Susan Bowers

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Jacob H. Bowers
6 (c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) March 13 1869

8. AGE: Years	Months	Days	If less than one day
78	9	16	hr. min.

9. Birthplace York County, PA. (Town, county and state)
10. Usual Occupation Retired Housework
11. Industry or business Retired

MOTHER / FATHER
12. Name Daniel Wackerman
13. Birthplace Lancaster Co. PA
14. Maiden Name Amanda Moorehead
15. Birthplace Lancaster Co. PA

16 (a) Informant Mrs. W. L. Allen
(b) Address Hallston, Md.

17 (a) Removal for Burial (b) Date thereof Dec 30-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. John's Cemetery
Location Littlestown, Pa.

18 (a) Funeral director J. W. Little & Son
(b) Address Littlestown, Pa. R. F. D. 4 Little

19 (a) (b)
(Date received by registrar) Livingston Williams Registrar

DEC 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1947 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29/47 to 12/28/47 and that I last saw h[er] alive on 11/27 1947.

Immediate cause of death: Chr Cholecystitis
Carcinoma of Pancreas — Duration 2 Yrs 6 Mos
Due to
Due to
Other Conditions Chr Myocarditis — 3
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Culbertson
Address 1901 Eutaw Place Date signed 12/30/47

J. E. Culbertson

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TN. G58413 115989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. G58413

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Poland

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1265 S. Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joe Kapela or Joe Caropello

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Agnes Kapela
6 (d) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 30/1882

8. AGE: Years	Months	Days	If less than one day
65	-	26	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Joseph Kapela
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Rd

18 (a) Funeral director John J Duda
(b) Address 2629 Hudson St

19 (a) DEC 28 1947 (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION A.M

20. DATE OF DEATH December 26th 1947, at 1.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 18th 1947 to Dec. 26 1947, and that I last saw h. im alive on Dec. 26/ 1947

Immediate cause of death Cardio-respiratory failure — Duration ?
Due to Left frontal lobe glioma
Due to
Other Conditions Art. sclerotic C-V disease, broncho pneumonia
(Include pregnancy within 3 months of death)
Date of operation 12/24/47
Major findings of operation: Left frontal lobe glioma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. N. Crosby
Address Balto. City Hosp. Date signed 12/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

✓ G58414 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 W. BALTIMORE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 627 W. BALTIMORE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELLA G RAYMER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife CHARLES L. RAYMER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/20/1866

8. AGE: Years	Months	Days	If less than one day
81	3	28	hr. min.

9. Birthplace WOODSBORO, FREDERICK Co. MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business OWN SELF

FATHER
12. Name WILLIAM STITLEY
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ELIZABETH NEUSEUR
15. Birthplace MARYLAND

16 (a) Informant MILDRED E. RAYMER
(b) Address 627 W BALTIMORE ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30-194 (month) (day) (year)
(c) Cemetery or crematory Rocky Hill Cem
Location Nr. Woodsboro. Md

18 (a) Funeral director M. L. Emerson-Ba
(b) Address Thurmont Md

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1947, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1947, to Dec 27 1947, and that I last saw h[illegible] alive on Dec 27 1947

Immediate cause of death: (a) Carcinoma of Uterus — Duration: 6 months
Due to: —
Due to: —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Schofield
Address Rt 1 Annapolis Md Date signed 12/27/47 M. D.

VS 150

B.C# 3-97651
G58415

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G58415 Registered No. 157 B

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. Josephs HOSPITAL 9 W
(d) Length of stay in hospital or inst. (yrs. mos. or days) /
(e) Length of stay in Baltimore (yrs. mos. or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 N. Aisquith ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wingate, Baby Boy
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/25/47
8. AGE: Years | Months | Days 1 | If less than one day 6 hr. min.
9. Birthplace BALTIMORE Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harold M. Wingate
13. Birthplace Va.

MOTHER
14. Maiden Name Eva V. Schaltz
15. Birthplace Balto. Md.

16 (a) Informant Harold M. Wingate
(b) Address 1512 N. Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

DEC 28 1947 (Date filed by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1947, at 5:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1947 to Dec 26 1947 and that I last saw h[illegible] alive on Dec 26 1947.

Immediate cause of death	Duration
CARDIO Resp - Failure	
Due to Asphyxia - ASPIRATION of Vomitus	
Due to PREMATURITY	
Other Conditions Meningocoele	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John B. Wells M. D.
Address 1400 N. Caroline St. Date signed 12/26/47

V S 150

159

G58416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G58416 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 East 21st St. #18
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME James L. Ryland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Elizabeth A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1879

8. AGE: Years	Months	Days	If less than one day
68	6	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Lacemaker Salesman
11. Industry or business

FATHER
12. Name John Ryland
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Lloyd
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 12/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location Harford Co. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St
19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 DEC 28 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1947, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 1947 to Dec. 27 1947, and that I last saw him alive on Dec. 27 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Hypertension and Cardio-Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Burkhart
Address Md. Med. Chirg. Date signed 12/29/47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a

Registered No. G58417

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Boyer + Rutland
(c) Hospital or institution W.B.G.H. West Balto. Md Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Ridgely St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Nannie Callahan Mallard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Charles W. Callahan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1st 1907

8. AGE: Years	Months	Days	If less than one day
40	5	26	hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Kyle Hamm
13. Birthplace W. Va.

MOTHER
14. Maiden Name Nancy McKinley
15. Birthplace W. Va.

16 (a) Informant Chas. W. Callahan
(b) Address 905 Ridgely St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md.

18 (a) Funeral director William Cook Inc.
(b) Address 517 St. Paul St.

19 (a) DEC 28 1947 (Date received by registrar) Thurlington Williams M.D. REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27-47 1947, at 10:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3- 1947, to 12-27 1947, and that I last saw her alive on 12-22- 1947

Immediate cause of death	Duration
Cardiac arrest	
Due to Exploratory Laparotomy	
Due to Carcinoma Bile duct obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12-27-47
Major findings of operation: Ca. Common duct obstruction
of autopsy: Pt. by Dr Thorpe

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W.W. Bindeman M.D. M. D.
Address West Balto. Md Hosp Date signed 12-27-47

VS 150

G58418 BALTIMORE CITY HEALTH DEPARTMENT G58418

CERTIFICATE OF DEATH 170c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 E 41st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET HILL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Chas. T. Hill

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) July 6 1882

8. AGE: Years 65 | Months 4 | Days 19 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Domestic Duties

11. Industry or business

FATHER
12. Name James Monahan
13. Birthplace Balto Md Ireland

MOTHER
14. Maiden Name Anne Langton
15. Birthplace Ireland

16 (a) Informant Frederick T. Hill
(b) Address 3100 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 1947 (month) (day) (year)
(c) Cemetery or crematory St Marys Govans
Location Roseland Ave

18 (a) Funeral director John G Moran
(b) Address 3000 Baltimore Blvd

DEC 28 1947 (Date rec'd by registrar) Winston Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1947, at 8.50 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture 10th dorsal vertebrae

Due to

Other Conditions Fract. left tibia & fibula, compound

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-25-47 at 8 p. m. 27/6
(b) Where did injury occur? Harford Rd. & Echodale Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by auto

23. Signature [signature] M.D. Medical Examiner

Date signed 12-26-47

658419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

658419 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1768 Homestead St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1768 Homestead St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary C. Butler

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/5/1867

8. AGE: Years 80 | Months 5 | Days 1921 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name William Butler

13. Birthplace Va

MOTHER 14. Maiden Name Mary C. McClothlan

15 Birthplace Md

16 (a) Informant Mrs Della Johnson

(b) Address 1768 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location old Frederick Rd

18 (a) Funeral director Robert Lowe

(b) Address 2318 Eutaw Pl

(c) DEC 29 1947 (Date rec'd by registrar) (d) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26-December 1947 at 2.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-Sept 1947 to 26-Dec 1947 and that I last saw h e alive on 26-Dec 1947

Immediate cause of death Coronary Thrombosis | Duration Sudden

Due to Arteriosclerotic Cardio Vascular Disease. | 6-Sept-47

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Chas W Edmunds M. D.

Address 2746 Ter Alameda Date signed 27 Dec 47

Victor Williams, M.D.

X

G58420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G58420 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 861 Park Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 861 Park Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Alexander Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Louise Heath
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 13, 1892

8. AGE: Years	Months	Days	If less than one day
55	7	13	hr. min.

9. Birthplace N. Y. C.
(Town, county, and state)
10. Usual Occupation clerk - B & O
11. Industry or business

FATHER
12. Name John S. Wilson
13. Birthplace Phila., Pa.

MOTHER
14. Maiden Name Katharine Dallett Hamphill
15. Birthplace Pa.

16 (a) Informant Louise Heath Wilson
(b) Address 861 Park Ave.

17 (a) Burial (b) Date thereof 12/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~Lutheran~~ National
Location Frederick Ave.

18 (a) Funeral director John O. Whitehill & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b) for Williams & Hill
(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1947 19 at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17, 1947 to Dec. 26, 1947 and that I last saw h~~e~~ alive on Dec. 26, 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension Arteriosclerosis	
Due to	
Other Conditions Cirrhosis Pulmonary Tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Goldberg M. D.
Address 622 W. North Ave. Date signed 12-27-47

VS 150

L. Goldberg 6-8 P. M. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G58421 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (~~year, month~~ or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Dundalk Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 8113 Bullneck Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Charles Enston

3 (b) If veteran, name war

3 (c) Social Security Account No. 429-01-4679

4. Sex: M

5. Color or race: White

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband~~ or wife: Emma V. Easton

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) June 1st, 1888

8. AGE: Years 59 | Months 6 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Investigator

11. Industry or business Md Casualty Co.

FATHER
12. Name Joseph Enston
13. Birthplace Germany

MOTHER
14. Maiden Name Lindemann
15. Birthplace Lindemann

16 (a) Informant Mrs. Emma Hackett Enston
(b) Address 8113 Bullneck, Rd Dundalk Md

17 (a) Burial (Burial, ~~cremation~~, removal) (b) Date thereof 12/29/47 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Pk
Location Sparrows Pt. Blvd, Balto Co. Md.

18 (a) Funeral director Harry E. Darby
(b) Address 1900 Eastern Ave Balto.

19 (a) Filed [illegible] (b) [illegible] Registrar

DEC 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26-47 19..., at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22 1947 to 12-26-1947 and that I last saw him alive on 12-26 1947

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to PULMONARY EMBOLI

Due to

Other Conditions DIABETES MELLITUS.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Monow Jr. M. D.
Address Md. Gen. Hosp. Date signed 12-26-47

1112

G58422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G58422 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4019 ParkHeights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4019 ParkHeights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1874

8. AGE: Years 73 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Joseph Tucker
13. Birthplace Russia

MOTHER
14. Maiden Name Mollie ?
15. Birthplace Russia

16 (a) Informant Rose Tucker
(b) Address 4019 ParkHeights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) DEC 28 1947 (Date received by registrar) (b) Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1945 to Dec. 27 1947, and that I last saw him alive on Dec. 27 1947

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Cerebral arteriosclerosis — 5 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Levin M. D.
Address 4818 Reisterstown Date signed Dec 27/47

G58423 BALTIMORE CITY HEALTH DEPARTMENT G58423
Registered No.

CERTIFICATE OF DEATH 160c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Streets
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 Min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (15) Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Dorithan Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Tucker

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-47

8. AGE: Years | Months | Days 1 | If less than one day 26 hr. 54 min.

9. Birthplace University Hospital Balto Md.
(Town, county, and state)

10. Usual Occupation Premature Infant.
11. Industry or business

FATHER 12. Name Samuel Tucker.
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Helen Sylvia Rother
15. Birthplace New York City, N. Y.

16 (a) Informant Mother
(b) Address 3301 Dorithan Rd. Balt. 15-Md.

17 (a) Burial (b) Date thereof 12/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bath Israel
Location Windsor Hill Road

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124 W. North Ave
Baltimore, Md.

19 DEC 28 1947 Thos. Worrington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Dec. 1947, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26 1947 to 12-27 1947, and that I last saw him alive on 12-27 1947.

Immediate cause of death	Duration
Cerebral Anoxia	
Due to Premature-Separation of placenta.	
Due to	
Other Conditions Fetal atelectasis Prematurity.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. C. Corey, M.D.
Address University Hospital Baltimore, Md. Date signed 12-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G58124 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1735 McKean Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 McKean Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR TABBS

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-5507

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Mary Jane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1883

8. AGE: Years 63 64 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace King & Queen Co. Va
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Prosser Tabbs
13. Birthplace Va

MOTHER
14. Maiden Name Hannah Robinson
15. Birthplace Va

16 (a) Informant Mrs. Mary J. Tabbs
(b) Address 1735 Mc Kean Ave.

17 (a) Burial (b) Date thereof Dec. 29, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Chas. H. Gallagher
(b) Address 1631 Druid Hill Ave

19 (a) Filed 28 (Rec'd by registrar) Thurlington Williams, Jr. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1947, at 9.30a M

21. I certify that I took charge of the remains described above, held an inspecting thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Carl A. Ryb M.D.
Medical Examiner.

Date signed 12-26-47

X

G58425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G58425 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Barkley St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9 1947

8. AGE: Years | Months 4 3 | Days 17 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

MOTHER / FATHER

12. Name Moses Johnson

13. Birthplace Md

14. Maiden Name Elsie Basil

15. Birthplace Md

16 (a) Informant Mrs. Mattie Johnson

(b) Address 1717 Barkley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1603 Druid Hill Ave.

19 (a) (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1947, at 8:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1947 to Dec 26 1947 and that I last saw her alive on Dec 26 1947.

	Duration
Immediate cause of death Cardio. resp. failure	
Due to Acute Nut. Dis. Intubation	
Due to Diarrhea	9 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Crigler Jr. M. D.

Address The Johns Hopkins Hosp. Date signed 12-26-47

VS 150

G58426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G58426

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3210 Guilford ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Guilford ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS JOSEPH COLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	216-10-1660

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Madeleine Morris Cole
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1889

8. AGE: Years	Months	Days	If less than one day
58	4	-	hr. min.

9. Birthplace Connecticut
(Town, county, and state)
10. Usual Occupation Printer's Foreman
11. Industry or business

FATHER
12. Name Joseph Cole
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Madeleine Morris Cole
(b) Address 3210 Guilford ave.

17 (a) Burial (b) Date thereof 12/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Chas. J. Evans & Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) Date received by registrar DEC 29 1947 (b) Signature of registrar Virginia Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Dec 24 1947
and that I last saw him alive on Dec 27 1947

Immediate cause of death	Duration
Coronary Thrombosis	18 days
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Kupicka M. D.
Address 600 Wilkens Ave Date signed 12/29/47

G58427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

G58427
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3846 Quarry Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 21 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3846 Quarry Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Catherine Maddox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Charles R. Maddox
6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) December 2, 1871

8. AGE: Years	Months	Days	If less than one day
76	---	26	hr. ... min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation ---
11. Industry or business

FATHER
12. Name Jack Hendrix
13. Birthplace Va.

MOTHER
14. Maiden Name Elisa Grishaw
15. Birthplace Va.

16 (a) Informant Hasley R. Maddox
(b) Address 1004 Overbrook Road

17 (a) Burial (b) Date thereof 12/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Fort Hill Burial Plot
Location Lynchburg, Va.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1500 Eutaw Place

19. (a) DEC 28 1947 (b) [illegible]
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1947, at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1947 to Dec 28 1947 and that I last saw h[illegible] alive on Dec 28 19 47

Immediate cause of death Respiratory failure — Duration

Due to Arteriosclerotic Cardio Vascular renal disease

Due to

Other Conditions Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. Sborofsky M.D.
M. D.
Address 601 N. Monroe St. Date signed 12/29/47

G58428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G58428 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 643 McKewin Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 643 McKewin Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME May A. Rosensteel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph L. Rosensteel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1875

8. AGE: Years	Months	Days	If less than one day
72	7	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward Rosensteel
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Burke
15. Birthplace Ireland

16 (a) Informant Mr. Rosensteel
(b) Address 643 McKewin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29/47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St

19 (a) DEC 28 1947 (Date rec'd by registrar) Washington Williams, M.D. Registrar

VS .150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1947, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947 to Dec. 26 1947, and that I last saw h[illegible] alive on Dec. 24 1946

Immediate cause of death	Duration
Myocardial Insufficiency	4 YRS -
Auricular Fibrillation	4 YRS
Due to Arteriosclerosis	4 YRS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. Young F. Cullen M.D.
Address 524 York Rd Date signed Dec 27/47

Dr. Cullen 5517 York Rd

G58429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G58429
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife William Carroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1853

8. AGE: Years	Months	Days	If less than one day
94			hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Steven
13. Birthplace

MOTHER
14. Maiden Name Nancy Elder
15. Birthplace

16 (a) Informant Estelle Linton, Niece
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Long Green, Md.

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St.

19 (a) (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1947 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10- 1947 to Dec 26 1947 and that I last saw her alive on Dec 26 1947

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chr-Myocarditis	8 yrs
Due to	
Other Conditions Arterio Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Bill Hall M.D.
Address 1621 E Monument Date signed Dec 27-47 M. D.

G58430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G58430 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.o.t
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha A. Margaret Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11, 1888

8. AGE: Years 59 | Months 3 | Days 14 | Unless less than one day hr. min.

9. Birthplace Harford County Md (Town, county, and state)

10. Usual Occupation Hairdresser

11. Industry or business

FATHER
12. Name Joseph Tate
13. Birthplace Md

MOTHER
14. Maiden Name Felicia Perkins
15. Birthplace Harford County Md

16 (a) Informant William H. Hawkins
(b) Address 411 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28/47 (month) (day) (year)
(c) Cemetery or crematory Sharp St Cemetery
Location Chase Md

18 (a) Funeral director Mr Pitt G. Elliott Dge
(b) Address 1129 N. Caroline St

19 (a) DEC 28 1947 (Date of registry) Ellington Williams (Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1947, at 8:1 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubenstein M.D. Medical Examiner.
Date signed 12/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 207

G58431 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 443 West 24th St. (If rural give location)
(e) Citizen of foreign country? (Name or No)
If yes, name country

3 (a) FULL NAME Mr. Lewis P. Compton

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	single

6 (b) Name of husband or wife None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 2, 1904

8. AGE: Years	Months	Days	If less than one day
43	5	24	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Roofing Work
11. Industry or business

FATHER
12. Name William Compton
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sophie Hess
15. Birthplace Baltimore, Md.

16 (a) Informant Mother - Sophie Hess
(b) Address 443 West 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30 1942 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director C. Benson Kerr Donovan
(b) Address 611-17 E. Chestnut St. Lancaster, Pa.

19 (a) (Date rec'd by registrar) (b) Registrar Washington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1942 at 5:50 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1942 to Dec 27 1942 and that I last saw him alive on Dec 27 1942

Immediate cause of death	Duration
Occlusion of Abd. Aorta	
Due to Arterial Thrombosis	
Due to Dissecting Aneurysm	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Montrose Kerr Miller
Address Union Memorial Hosp. Date signed 12-29 M.D.

X

G58432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58432
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 49 y.

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 N. Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary (Hardy) Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-5949

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Frederick D. Harrison
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/18/98

8. AGE: Years	Months	Days	If less than one day
49	4	7	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lankenau
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 12-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn County
Location Westport Road

18 (a) Funeral director George P. A. Gibson
(b) Address 1736 Druid Hill Ave

19 (a) Thos. Covington Williams, M.D. Registrar
(Date received by registrar)
DEC 29 1947

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1947, at 11:25 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1947 to 12/25 1947 and that I last saw her alive on 12/25 1947.

Immediate cause of death Subarachnoid Hemorrhage — Duration 15 m.
Due to Hypertensive C-V Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carter Hunt M.D.
Address 1514 Division Date signed 12/27/47

X

G58433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 37

G58433 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2038 Bank St
(c) Hospital or institution: 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2038 Bank St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Karl Gustav Ojason

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-09-2427

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M.

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Dec. 28 1882

8. AGE: Years 64 66? | Months 11 | Days 29 | If less than one day ____hr. ____min.

9. Birthplace Riga Russia
(Town, county and state)

10. Usual Occupation Machinist

11. Industry or business Retired

FATHER
12. Name Karl O'Jason
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant Anna M. O'Jason
(b) Address 2038 Bank St

17 (a) Burial (b) Date thereof 12 29 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Dapple & Smithers
(b) Address Lombard & Conv St

DEC 28 1947 (b)
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1947 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1945 to Dec 26 1947, and that I last saw him alive on Dec 26 1947

Immediate cause of death	Duration
General Arteriosclerosis	3 yrs
Pulmonic Myocarditis	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Melrose C Solomon
Address 129 S Woodward Date signed 12/29/47

G58434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (581)

G58434 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital 7-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank J. Rose ✓

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15 1932

8. AGE: Years 15 | Months | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Alphonse J Rose
13. Birthplace Balto

MOTHER 14. Maiden Name Grace Vecere
15. Birthplace Balto

16 (a) Informant Alphonse J. Rose
(b) Address 523 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 30 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Mark H. Cooper & Sons
(b) Address 375 S

19 (a) 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1947, at 10[19] M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1947 to 12-26 1947, and that I last saw him alive on 12-26 1947.

	Duration
Immediate cause of death: Acute Glomerular Nephritis	
Due to:	
Due to:	
Other Conditions: Rheumatic Heart Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address 1400 N. Caroline St Date signed 12/26/47

130

G58435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58435

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Yosemite Avenue
(c) Hospital or institution: 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Yosemite Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Barry

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 219-07-4794

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Martha E. Barry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12-1869

8. AGE: Years 78 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Boston, Mass.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Patrick Barry
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget M. Brady
15 Birthplace Boston, Mass

16 (a) Informant Mrs Martha E. Barry
(b) Address 3706 Yosemite Avenue.

17 (a) Removal (b) Date thereof Dec 28th 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holyhood
Location Brookline, Mass.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 DEC 29 1947 Huntington Williams M.D.
(Date received by Registrar) (Registrar)

VS 159.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1947, at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31 1946 to 12/28 1947 and that I last saw h~~im~~ alive on 12/27 1947.

Immediate cause of death: Myocardial insufficiency — Duration: 3 mo.
Due to: Arteriosclerotic heart disease — 14 mo.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Reiter
Address 340 W Windsor Ave. Date signed 12/28/47 M. D.

658436 Gillespie X 658436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5002 Frederick Rd
(c) Hospital or institution:
The Sunday Sanitarium - Catholic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Cecil
(c) City or town Port Deposit
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Alice A. Gillespie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William A. Gillespie
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) 4 26 71

8. AGE: Years 76 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Maryland -
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business -

FATHER 12. Name Edward Brown
13. Birthplace Maryland

MOTHER 14. Maiden Name Anna Malonson
15. Birthplace Md.

16 (a) Informant William A Gillespie
(b) Address Temple Md.

17 (a) Burial (b) Date thereof Dec 31, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hopewell
Location Port Deposit, Md. Rural

18 (a) Funeral director Lee A. Patterson & Son
(b) Address Perryville, Md.

19 (a) DEC 29 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1947, at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 19 1943, to Dec 29 1947, and that I last saw him alive on Dec 29 1947.

Immediate cause of death	Duration
Acute Gastritis	12 hrs
Due to General debility	1 wk
Due to Arteriosclerosis - General	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rachel K. Sunday M. D.
Address The Sunday Sanitarium Catholic Date signed 12-29-47

PLEASE WRITE PLAINLY, WITH INK. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 2

X

658437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

658437
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hosp. 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 W. Lee Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	W. Dowed

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1880

8. AGE: Years	Months	Days	If less than one day
67	3	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Greenberry Warfield
13. Birthplace Maryland

MOTHER
14. Maiden Name Priscilla Warthen
15. Birthplace Maryland

16 (a) Informant Mrs. Emory Burdette
(b) Address Monrovia, Maryland

17 (a) Burial (b) Date thereof 12/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Mt Airy, Md

18 (a) Funeral director John F. Dennyoyer
(b) Address 714 Light St.

19 (a) 12 29 1947 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1947, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1947 to 12/27 1947 and that I last saw here alive on 12/27 1947.

Immediate cause of death	Duration
Acute Cardiac Failure; Generalized Arteriosclerosis.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert M. Carouge M. D.
Address 6226 Everall Ave Date signed 12-27-47

X

G58438 # 4-10053 BALTIMORE CITY HEALTH DEPARTMENT G58438

CERTIFICATE OF DEATH ✓ 54 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33rd & Calvert Sts.
(b) Street address 3334 Kimble Road
(c) Hospital or institution: Union Memorial Hospital 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3334 Kimble Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Clyde Calvin Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/30/44

8. AGE: Years	Months	Days	If less than one day
3	2	28	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER
12. Name Clyde Carroll Hammond
13. Birthplace Balto.

MOTHER
14. Maiden Name Lillian Bessie Shuler
15. Birthplace New York

16 (a) Informant Father
(b) Address Same.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1317 St. Paul St.

19 (a) DEC 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1947 at 1:29 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1947 to 12/28 1947, and that I last saw h— alive on 12/28 1947

Immediate cause of death Respiratory failure — Duration

Due to Brain tumor — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation 12/19/47

Major findings of operation Inoperable brain tumor w/ congestal-

of autopsy: genital failure

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gary M. Fox M.D.
Address U.M.H. Date signed 12/29/47

X

G58439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G58439 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.H.
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 S. Franklintown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Phillips

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Harriett Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18 1868

8. AGE: Years	Months	Days	If less than one day
79	2	9	hr. min.

9. Birthplace Nassau N Y
(Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business New York State

FATHER
12. Name David Phillips
13. Birthplace New York N Y

MOTHER
14. Maiden Name Lois O'Dell
15. Birthplace New York N Y

16 (a) Informant Harriett Phillips
(b) Address 301 S Franklintown Rd

17 (a) Funeral (burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)
(c) Cemetery or crematory Nassau
Location Nassau Rensselaer Co N Y

18 (a) Funeral director Tilhou & Dye
(b) Address 12 W 72 St

DEC 29 1947 (Date rec'd by registrar) (Signature for Williams M.D.)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1947, at 5:50 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. J. Sullivan M.D.
Medical Examiner.
Date signed 12/29/47

G58440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G58440 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 Mosher St
(c) Hospital or institution: None 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie R. Thomas

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	colored	Widowed

6 (b) Name of husband or wife Charles G. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 24 1860

8. AGE: Years	Months	Days	If less than one day
87	7	0	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Matthews
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine Lewis
15. Birthplace Md.

16 (a) Informant Lillie M. Banks daughter
(b) Address 419 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director John M. Johnson
(b) Address 1760 Druid Hill Ave

19 (a) DEC 29 1947 (Date received by registrar) (b) Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1947 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16, 1947 to Dec 24 1947 and that I last saw her alive on Dec 23, 1947,

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. F. Scott M. D.
Address 354 N. Bradford Date signed 12-26-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. G58441

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St. 18-3
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 1/2 W. Lombard St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK ADAMITIS

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Miner

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Joseph Adamitis
(b) Address 816½ W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Joseph Kusmaka
(b) Address 607 N Washington Blvd

19 (c) DEC 29 1947 (Date rec'd by registrar) Registrar Washington

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1947, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17 1947 to Dec. 25 1947, and that I last saw him alive on Dec. 25 1947.

Immediate cause of death	Duration
Tuberculous pentrate Pulmonary Tuberculosis	
Due to Tuberculous silicosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert M. Carouge M. D.
Address 6226 Everall Ave. Date signed 12-25-47

VS 150

G58142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G58142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-2
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 Herkimer St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARCELLA BRIOICKAS

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace LITHUANIA (Town, county, and state)

10. Usual Occupation HW

11. Industry or business

FATHER
12. Name Anthony PULAKIS
13. Birthplace Lithuania

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant Soloman Bredikas
(b) Address 1319 Herkimer St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Joseph Kasunskas Sr
(b) Address 60 W Washington Blvd

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Wm Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27-47 19 , at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7-47 19 , to 12-27-47 , and that I last saw her alive on 12-27-47 .

Immediate cause of death	Duration
Debility	
Due to Carcinoma of Stomach & pancreas	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-15-47

Major findings of operation: Carcinoma of Stomach & pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank D. Brady M. D.
Address md. Gen. Hosp. Date signed 12-27-47

G58443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G58443

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Mt. Royal Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Nellie Doyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) Sept 3 1859

8. AGE: Years 75 77 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Doyle
13. Birthplace New Jersey

MOTHER 14. Maiden Name Mary Mulvehill
15. Birthplace New Jersey

16 (a) Informant Mrs. John Byrne
(b) Address 1716 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/47 (month) (day) (year)
(c) Cemetery or crematory St Mary's Cem
Location Salem New Jersey

18 (a) Funeral director J. F. Zoheir & Sons
(b) Address 1218 Pulaski St

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1947 at 9:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1947 to 12/27 1947 and that I last saw her alive on 12/27 1947

Immediate cause of death	Duration
Acute Cardiac failure due to pulmonary edema.	
Due to Arteriosclerotic C.V.D.	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Josie L. Valderas M. D.
Address St Agnes' Hospital Date signed 12-27-47

93D

G58444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58444 Registered No.

GM. 115381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 O'Donnell ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Kraus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16 - 1873

8. AGE: Years	Months	Days	If less than one day
74	1	6	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Kraus
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Cramer
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Germain Hill Rd.

18 (a) Funeral director John J. Fahey & Sons
(b) Address 1368 Light St.

19 (a) DEC 29 1947 (b) Huntington Williamsville N.Y.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 - 1947 at 6.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 - 1947 to Dec. 22 1947, and that I last saw h im alive on Dec. 22- 1947

	Duration
Immediate cause of death Bronchopneumonia PHL	4 days
Due to	
Due to Carcinoma of Pancreas	?
Due to	
Other Conditions Generalized Arteriosclerosis, Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 12-26-47

058445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 A

Registered No. 058445

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 No Smallwood St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15.3
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 No Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Foreman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1874

8. AGE: Years 73 (80) | Months - | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Louis Foreman
(b) Address 1609 No Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-47 (month) (day) (year)

(c) Cemetery or crematory Adas Israel
Location No Point & German Hill Rd

18 (a) Funeral director Jack Kevin Inc
(b) Address 2160 Eastern Place

19 DEC 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28-1947, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1946 to Dec 28 1947, and that I last saw h[illegible] alive on Dec 28 1947.

Immediate cause of death: Coronary Occlusion Cardio-Vascular-Renal Failure — Duration: 10 years 2 mos

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Lachman M. D.
Address 2 P 2 Baltimore MD Date signed Dec 28 1947

I Lachman

C58446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C58446

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1829 No Charles St

(c) Hospital or institution 12-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1829 No Charles St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Esther Fletman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Fraiss

13. Birthplace Russia

MOTHER 14. Maiden Name Darah

15. Birthplace Russia

16 (a) Informant Charles Fletman

(b) Address 1829 No Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-47 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Bel Fernon Hall Rd.

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Pl

19 DEC 29 1947 (Date rec'd by registrar) (b) Livingston Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27-1947, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Dec 27 1947 and that I last saw her alive on Dec. 27 1947

Immediate cause of death: Coronary Thrombosis — Duration: 3 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Manuel Lewis

Address 4818 Reisterstown Rd Date signed Dec 28 1947 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1862

Registered No. 058147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Elkridge (If outside city or town limits, write RURAL and give town)
(d) Street No. Railroad Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia A. Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ James L. Young

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14th 1855

8. AGE: Years	Months	Days	If less than one day
92	10	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Zachus Isbael
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Jane ?
15. Birthplace Md.

16 (a) Informant Francis R. Crowson
(b) Address Railroad Ave. Elkridge Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) (Date received by Registrar) DEC 29 1947 (b) Huntington Williams M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22 1947, to 12-28 1947 and that I last saw her alive on 12-28 1947.

Immediate cause of death	Duration
Pneumonia	
Due to Arteriosclerotic heart disease & decompensation	
Due to	
Other Conditions Fracture Rt. neck of left femur	

(Include pregnancy within 3 months of death)

Date of operation 0
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If ~~death~~ was due to external causes, fill in the following: 63-00
(a) Accident, ~~suicide~~, or homicide
(b) Date of occurrence Dec 22, 1947 at M
(c) Where did injury occur? Baltimore, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell down steps

23. Signature Earl H. Royer M.D.
Address University Hosp. Date signed 12-29-47

Earl H. Royer M.D.

aboard S.S. Pinedale G58448

G58448

BALTIMORE CITY HEALTH DEPARTMENT mid Atlantic

CERTIFICATE OF DEATH 1947 Registered No. 12/21/47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Hurst Street
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Somerville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 62 Broomfield Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles GRIFFIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1903

8. AGE: Years 44 | Months 6 5 | Days 29 | If less than one day hr. min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER 12. Name Thomas A. Griffin

13. Birthplace Mass.

MOTHER 14. Maiden Name Catherine Tucker

15. Birthplace Mass.

16 (a) Informant Mary L. McDonald

(b) Address West Summerfield Mass.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29 1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Rd.

18 (a) Funeral director Harry H. Witzke

(b) Address 1101 Edmondson Ave

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Williams Mar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1947, at 12 10 PM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial hypertrophy, dilatation and degeneration.
Due to Acute pulmonary edema

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/24/47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58449 B.C 43-9518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C58349 / 157 G

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1.G. N. Cachoun 57.
(c) Hospital or institution: Franklin Sq Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2a days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5552 Ash Bourne Rd (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cook, Baby Girl, Carlyn May Cook

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5: 1947

8. AGE: Years	Months	Days	If less than one day
		20	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Cook, John
13. Birthplace Md.

MOTHER
14. Maiden Name Lowman Virginia
15. Birthplace Md.

16 (a) Informant John Cook. (Father)
(b) Address 555 2 Ashbourne Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3401 Frederick Ave

18 (a) Funeral director Harry H Wilyle
(b) Address 4101 Edmondson Ave.

19 DEC 29 1947 (b) Huntington-Williams, Md
(Registered by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5 1947 to 12-25 1947 and that I last saw h alive on 12-25 1947

Immediate cause of death	Duration
(a) Pneumonia	
(b) Jaundice - Encephalopathy	
Due to Peritonitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard J. Caplan M. D.
Address Franklin Sq Hosp Date signed 12-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58450

CERTIFICATE CORRECTED 12-11-51

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G58450 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Chapel Gate
(c) Hospital or institution:
Pine Crest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mo 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5600 Roxbury Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Annkliese Grossman~~ Anna Elise Grossmann

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. ~~Grossman~~ Grossmann
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan. 13, ~~1870~~ 1876

8. AGE: Years	Months	Days	If less than one day
71 68	11	14	hr. min.

9. Birthplace Brotterode, Schmalkalden/Meiningen Germany
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andreas Karl Valsch
13. Birthplace Brotterode, Schmalkalden/Meiningen Germany

MOTHER
14. Maiden Name Emilie Franziska Clise Thuerer
15. Birthplace Brotterode, Schmalkalden/Meiningen Germany

16 (a) Informant Mr. Frank Roberts
(b) Address 5600 Roxbury Place

17 (a) Cremation (b) Date thereof Dec. 29, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Crematory
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tockner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. Md.

19 (a) DEC 29 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947, to 27 Dec 1947, and that I last saw ~~him~~ her alive on 27 Dec 1947.

Immediate cause of death Cerebral hemorrhage — Duration
Due to Arteriosclerotic vascular disease, with cerebral
Due to degeneration.
Other Conditions Schizophrenia, Catatonic
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Emil H. Henning Jr. M.D.
Address 4580 Edmondson Ave Date signed 28 Dec 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

Registered No. 658151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Glenelg (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Jane Elizabeth Pfefferkorn
3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: — None
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Samuel L.
6 (c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): July 6 1899
8. AGE: Years 48 Months 5 Days 20 If less than one day: hr. min.
9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Walter C Roberts
13. Birthplace: Tarboro, N. C.

MOTHER
14. Maiden Name: Mamie Polack
15. Birthplace: North Carolina

16 (a) Informant: Hospital Patient Husband
(b) Address: Glenelg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)
(c) Cemetery ~~xxxxxxxx~~ St. John's Cem.
Location Ellicott City, Md.

18 (a) Funeral director: WM. J. TICHNER & SONS INC.
(b) Address: North & Pa. Aves. Balto. 17, Md.

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Wittenmyer

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26 1947 at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1942 to Dec 26 1947 and that I last saw h[illegible] alive on Dec 26 1947

Immediate cause of death: Uremia — Duration:

Due to: Bilateral hydronephrosis

Due to: Carcinoma of cervix with enlarged L. & R. inguinal nodes and metastasis to liver

Other Conditions: Laparotomy anemia, acute vaginal hemorrhage

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Bilateral hydronephrosis Uremia Carcinoma of cervix & liver

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Arnold Field M. D.
Address: Womans Hospital Date signed: Dec 26, 1947

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58452 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G58452

CERTIFICATE OF DEATH ✓ 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Poplar Terrace
(c) Hospital or institution: 15T
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city proper limits, write RURAL and give town)
(d) Street No. 3008 Poplar Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Francis Foley

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	217-18-1285	M	W	Married

6 (b) Name of husband or wife Ellen Foley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11th 1902

8. AGE: Years	Months	Days	If less than one day
45	7	16	hr. min.

9. Birthplace St Johns, N. F. (Town, county, and state)
10. Usual Occupation Book-keeper
11. Industry or business Feldmans, Inc.

FATHER
12. Name John Foley
13. Birthplace St Johns, N. F.

MOTHER
14. Maiden Name Mary E. Kelly
15. Birthplace St Johns, N. F.

16 (a) Informant Mrs. Ellen Foley
(b) Address 3008 Poplar Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30-1947 (month) (day) (year)
(c) Cemetery Woodlawn
Location Woodlawn, Balto Co., Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/47 19 at 8:55 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 12/27/47

VS 191

G58453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 F

Registered No. G58453

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — 1a 4321
(b) Street address
(c) Hospital or institution: Mercy Hospital 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 5204 Midwood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret N. Evans MARGARET NEAL EVANS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband or wife Thomas Steel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/26/85 2/26/85

8. AGE: Years	Months	Days	If less than one day
62	10	1	hr. min.

9. Birthplace Harford County (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Frank J Neal
13. Birthplace — Pa

MOTHER
14. Maiden Name Ella Bicknell deceased
15 Birthplace Pa

16 (a) Informant Mr. Thomas Steel Evans
(b) Address 5204 Midwood Ave. 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17. Md

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1947, at 1.36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1947 to Dec 27 1947 and that I last saw h[illegible] alive on Dec 27 1947

Immediate cause of death: Carcinomatosis — Duration

Due to:

Due to:

Other Conditions: Ascites

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H B Scott M.D.
Address Mercy Date signed 12/6/47

658454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No. 658454

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5107 LINDEN HGTS AVE.
(c) Hospital or institution: 27-18

(d) Length of stay in ~~hospital or inst.~~ ABOVE ADDRESS (yrs., mos., or days) 2 WKS

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5107 LINDEN HGTS AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM D. BURROWS

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARIA A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 21, 1900

8. AGE: Years 47 | Months 2 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace BALTO. MD.
(Town, county, and state)

10. Usual Occupation BRICK LAYER

11. Industry or business CONSOLIDATED ENGR CO INC

FATHER
12. Name DENNY W. BURROWS
13. Birthplace ST. MICHAELS, MD.

MOTHER
14. Maiden Name EFFIE GRANGER
15. Birthplace MD.

16 (a) Informant MRS. MARIE A. BURROWS
(b) Address 5107 LINDEN HGTS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)

(c) Cemetery or ~~crematory~~ LOUDON PARK
Location BALTO. MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address NORTH & PA AVES BALTO. MD

19 DEC 29 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1947, at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1947 to Dec 26 1947
and that I last saw h~~im~~er alive on Dec 26 1947

Immediate cause of death: Anaplastic Carcinoma — Duration: Unknown

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation NOV. 1947

Major findings of operation: Retroperitoneal Carcinoma metastatic.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Ackerman M.D.

Address 19 W. Mulberry Ave Date signed 12/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49c

Registered No. C58455

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 N.Castle St
(c) Hospital or institution: 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N.Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christina H.Glock

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Herbert J.Glock
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): June 21,1889
8. AGE: Years 58 | Months 6 | Days 4 | If less than one day hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: Jerry Gerrod
13. Birthplace: England

MOTHER
14. Maiden Name: Annie Heiner
15. Birthplace: Germany

16 (a) Informant: Herbert J.Glock
(b) Address: 206 N.Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.29/47 (month) (day) (year)
(c) Cemetery or crematory: Trinity Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Henry Sons
(b) Address: 2024 Orleans St.

19 (a) Dec 29 1947 (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25. 1947 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Dec 25 1947 and that I last saw her alive on Dec 25 1947.

Immediate cause of death	Duration
Carcinoma Gall Bladder	1 yr.
Due to Pelvis & Ureter	
Due to Ileum, Stomach	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Date signed 12-30-47

G58158
AB-115949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V-13B

G58456
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 14yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 W. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Jerow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Roselie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7- 1922

8. AGE: Years	Months	Days	If less than one day
25	0	19	hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Jerow
13. Birthplace S.C.

MOTHER
14. Maiden Name Mattie Durant
15. Birthplace S.C.

16 (a) Informant Record-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof 12-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sinai
Location

18 (a) Funeral director Isaiah L Brown
(b) Address 108 W Montgomery St

19 DEC 29 1947 (b) Emmitt Co. Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26- 19 47, at 10.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16- 19 47 to 12-26- 1947, and that I last saw him alive on 12-26- 1947

Immediate cause of death	Duration
Respiratory Failure	hrs
Due to Far. adv. cases - pulmonary tbc & carcinoma	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation -
Major findings of operations: -
of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jordan Craft M. D.
Address Balt. City Hosps Date signed 12/26/47

X

V S 150

C58457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C58457

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 330 r Hayward ave
(c) Hospital or institution: 271
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 r Hayward ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victor F Jositis

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-8134

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	married

6 (b) Name of husband or wife Grace B Jositis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1890

8. AGE: Years	Months	Days	If less than one day
57	0	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Cutter
11. Industry or business Clothing

FATHER
12. Name Geo Jositis
13. Birthplace Lithuania

MOTHER
14. Maiden Name unknown
15. Birthplace Lithuania

16 (a) Informant Grace Jositis
(b) Address 330 r Hayward ave Balto 15

17 (a) Burial (b) Date thereof 12-31-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director F C Nigrubolton
(b) Address Ellicott City Md.

19 (a) DEC 29 1947 (b) Thurlington Williams M.D.
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1947, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1947, to Dec 27 1947, and that I last saw him alive on Dec 27 1947.

Immediate cause of death	Duration
Coronary Embolism	1 day
Due to —	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward J Bass
Address 5276 Park Hts Date signed Dec 27

X 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 A

Registered No. G58458

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 758 George Street
(c) Hospital or institution: 173
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 758 George St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN HOLBROOK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1895

8. AGE: Years	Months	Days	If less than one day
52	2	12	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Warner Woodfork
13. Birthplace Va.

MOTHER
14. Maiden Name Estelle Jones
15. Birthplace Va.

16 (a) Informant M's Dorothy Pratt
(b) Address 758 George Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Anne Arundel Co. Md.,

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) DEC 29 1947 (Date received by registrar) (b) Huntington for Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1947, at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1947, to Dec 27 1947, and that I last saw h. alive on Dec 26 1947.

Immediate cause of death	Duration
Cerebral Hemmorhage	
Due to Hypertension	10 yrs
Due to Uremia	
Other Conditions Marked Obesity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Garland Chiswell M. D.
Address 902 W Franklin St Date signed 12-27-47

VS 188.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D.C 4-8329

58459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 058459

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523- East Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM GOUGH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7- -1947

8. AGE: Years	Months	Days	If less than one day
	5		hr. min.

9. Birthplace Baltimor md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Franklin Gough
13. Birthplace St Marys Co md

MOTHER 14. Maiden Name Carrie Anderson
15. Birthplace St marys co md

16 (a) Informant Franklin Gough
(b) Address 523 N. East St

17 (a) Burial (b) Date thereof Dec 29. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brantly ave

19 DEC 29 1947 (b) Investigator
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1947, at 12.25 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Status thymico - lymphaticus

Due to

Other Conditions Edema - Congestion of lungs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 12-27-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓180

Registered No. G58460

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 ~~Broom~~ St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FLORENCE McKIM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife George McKim

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1883

8. AGE: Years	Months	Days	If less than one day
64	10	11	hr. min.

9. Birthplace Ellicot City Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Welch
13. Birthplace Maryland

MOTHER
14. Maiden Name Nancy Williams
15. Birthplace U.S.

16 (a) Informant Beulah Buckner
(b) Address 530 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 DEC 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1947, at 11.20 P M

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Burns 3rd degree entire body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 17-3

(a) Date of injury 11-25-47 at 11 p. M.
(b) Where did injury occur? 602 Broom St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fire

23. Signature Earl L Royer M.D. (Medical Examiner)
Date signed 12-26-47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 166

Registered No. G58461

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2520- Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME HANNIBAL BOWIE.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife Alberta

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov-28-1904

8. AGE: Years	Months	Days	If less than one day
38	8	28	.....hr. .....min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name John Bowie
13. Birthplace Md

MOTHER
14. Maiden Name Maria ?
15. Birthplace Md.

16 (a) Informant Alberta Bowie
(b) Address 2520 Penna. Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-30-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave.

19 (a) DEC 29 1947 (Entered by registrar) (b) Hunting for Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1947, at 6.05PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of heart

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-26-47 at 6.05 p. M.
(b) Where did injury occur? 1303 Penna. Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury. Firearms

23. Signature Carl A. Kyler, M.D.
Medical Examiner.
Date signed 12- 12-27-47

G58462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G58462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1149 Myrtle Avenue
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1149 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME FLORENCE DORAM

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Fn

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Thomas Doram

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Apr 26, 1891

8. AGE: Years 56 | Months 8 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace St. Mary's Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alosia Jackson
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Mason
15. Birthplace Maryland

16 (a) Informant John Thomas Doram
(b) Address 1149 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director Charles R? Law
(b) Address 802 Madison Avenue

19 (a) DEC 29 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended ~~deceased~~ from 12/27/47 to 19..., and that I last saw h[illegible] alive on 12/27/47

Immediate cause of death	Duration
Acute Coronary Occlusion	
Due to Hypertension 2 yrs	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H C Welcome HENRY C. WELCOME M. D.
Address 1131 Harlem Ave Date signed

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58463

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 Rutland Ave
(c) Hospital or institution: 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel B Bell Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10th 1880

8. AGE: Years 67 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Fireman

FATHER
12. Name Samuel Bell
13. Birthplace Md

MOTHER
14. Maiden Name Palastine Bradley
15. Birthplace Md

16 (a) Informant Mrs Sarah Bell
(b) Address 1715 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30th 1937 (month) (day) (year)
(c) Cemetery or crematory Balto
Location E. of North Ave Ext.

18 (a) Funeral director Leo G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Dec 29 1937 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1937, at 4:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1937 to Dec 27 1937 and that I last saw h alive on Dec 26 1937.

Immediate cause of death	Duration
Congestive Heart Failure	3 days
Due to Cardio-Vascular Hypertensive disease	1 year
Due to Arteriosclerosis	6 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael J. Dausch M. D.
Address 1 W. Overlea Ave Date signed 12/27/37

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58464

AB-116089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G58464

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 Bank Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Szydlowski ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-1921

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Madeline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospital
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec. 31-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 DEC 29 1947 Huntington Williams, Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1947, at 5.55PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24- 1947 to 12-26- 1947 and that I last saw h im alive on 12-26- 1947.

Immediate cause of death Cardiac failure — Duration 12 hrs.

Due to: dissecting aneurysm — days

Due to luetic heart disease & aortic insufficiency — yrs.

Other Conditions Hypertension — yrs.

(Include pregnancy within 3 months of death)

Date of operation 12/25/47

Major findings of operation: na

pathology of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Craft

Address Balt. City Hosps Date signed M. 12 D. 30/47

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248

Registered No. 658465

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2-2
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Do Cannot tell
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 S. Ann St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Josephine Pelanowski

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Simon Pelanowski
6 (c) If alive, give age + years

7. Birth date of deceased (mo., day, yr.) march 19 1877

8. AGE: Years	Months	Days	If less than one day
69	8	8	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name ? unknown
13. Birthplace Poland

MOTHER
14. Maiden Name ? unknown
15. Birthplace Poland

16 (a) Informant Mrs. Veronica Fijewski
(b) Address 308 S. Ann St. Balto.

17 (a) Burial (b) Date thereof 12-30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern ave

19 (a) (Date received by registrar) (b) Registrar Washington Williams M.D.

DEC 29 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/47 19 , at 1:37 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23/47 19 , to 12/27/47 , and that I last saw h[illegible] alive on 12/27/47

Immediate cause of death	Duration of
Cholecystitis, & Cholelithiasis,	chronic
Due to cirrhosis of liver	
Due to Artery is calcerated last surgery 5 Carbuncle	
Other Conditions Decompensation	

(Include pregnancy within 3 months of death)
Date of operation no operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph J. Antonio M. D.
Address Church Home & Hosp Date signed 12/29/47

X

G58466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G58466

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5910 Park Heights Avenue
(c) Hospital or institution: 27-20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5910 Park Heights Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lottie D. Hicks

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles A. Hicks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9 1871

8. AGE: Years	Months	Days	If less than one day
76	10	18	hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Levi Chambers
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Holland
15. Birthplace Maryland

16 (a) Informant Mrs. Elizabeth Baker
(b) Address 5916 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1947, at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1947, to Dec 27 1947, and that I last saw h[illegible] alive on Dec 26 1947.

Immediate cause of death	Duration
Terminal Pneumonia	2 days
Due to Cardiac decompensation	6 wks.
Due to Chronic Parkinsonism - cerebral disease.	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 5916 Park Heights Ave. Date signed 12/29/47.

X

C58467

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. C58467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Falls Road 2715
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Edith E. Yewell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: William D. Yewell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20. 1864

8. AGE: Years 83 | Months 10 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Norfolk, Virginia (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant James M. Yewell
(b) Address 1909 E. 31st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29. 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 2631 Falls Road

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1947 at 9.40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1947 to Dec 26 1947, and that I last saw h CY alive on Dec 25 1947

Immediate cause of death: Arteriosclerotic CVD & Decomp. — Duration: 2 wks

Due to: Generalized Arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence J. Lamont M.D.
Address 3711 Falls Rd Date signed 12-26-47

ALICE MARY MECHALSKE

C58468 TN. 116097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. C58468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 138
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 Falls Road
(If no No. give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Mary Mechalske

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-18-4695

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Sherman L. Mechalske
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22-1894

8. AGE: Years	Months	Days	If less than one day
? 53	10	15	hr. min.

9. Birthplace Grand Rapids Michigan
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name J. P. Hosey
13. Birthplace Mo.

MOTHER
14. Maiden Name Mary Alice Fallon
15. Birthplace Illinois

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30-1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27th 1947 at 12.50 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24/ 1947 to Dec 27 1947 and that I last saw h[illegible] alive on December 27/1947

Immediate cause of death Cerebral Vascular Accident & Int. Hemorrhage

Due to Hypertension

Due to Coronia Thrombosis Disease

Other Conditions Diabetes mellitus mild

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Negative

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Keating Jr. M.D.
Address Balto City Hosp Date signed 30 Dec 47

937

G58469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1176

Registered No. G58469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST. & RUTLAND AVE.
(c) Hospital or institution: SINAI HOSPITAL 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Aisquith St (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA TAYLOR

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife SAMUEL TAYLOR
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) August 31 1895

8. AGE: Years	Months	Days	If less than one day
52	3	28	hr. min.

9. Birthplace Anne Arundel Co. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm Dorsey
13. Birthplace ?

MOTHER
14. Maiden Name Mary Ellen ?
15. Birthplace ?

16 (a) Informant Samuel Taylor
(b) Address 1601 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/47 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Taylor Ave - Parkville

18 (a) Funeral director J. Melville Jenkins
(b) Address 2713 Kirk Ave.

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 28, 1947, at 12 N.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Peritonitis, generalized	
Due to Duodenal Ulcer, ruptured	
Due to	
Other Conditions Hypertension CVD.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Crosthwait, M.D.
Address Sinai Hospital Date signed 12-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G58470

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2018 N. Wolfe Street
(c) Hospital or institution: 8-S
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 N. Wolfe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WILLIAM WOLFE

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-09-3862

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frances I. Wolfe
6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Feb. 17, 1886

8. AGE: Years: 61 | Months: 10 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business: Baltimore Transit Co.

FATHER
12. Name: John R. Wolfe
13. Birthplace: Penna.

MOTHER
14. Maiden Name: Mary Corbin
15 Birthplace: Carroll County, Md.

16 (a) Informant: Mrs. Francis I. Wolfe
(b) Address: 2018 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) DEC 29 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH December 26 1947, at 3.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1947 to Dec 26 1947, and that I last saw h IM alive on Dec. 26 1947.

Immediate cause of death	Duration
Carcinoma of Lung	
Due to ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Tourbert M.D.
Address 441 N. Kelwood Rd. Date signed 12/28/47

X

G58471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G58471

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 WASHINGTON BLVD.
(c) Hospital or institution: 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 WASHINGTON BLVD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA SHELDON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	WHITE	WIDOWED

6 (b) Name of husband or wife JOHN SHELDON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 1867

8. AGE: Years	Months	Days	If less than one day
80	6		hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business OWN HOME

FATHER
12. Name JOHN WISE
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN FRENCH
15. Birthplace "

16 (a) Informant MARIE SHELDON
(b) Address 814 WASHINGTON BLVD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-28-47 (month) (day) (year)
(c) Cemetery or crematory LOUDEN PK.
Location FREDERICK AVE.

18 (a) Funeral director Joseph J. Gaylord, Jr.
(b) Address 414 N. Franklintown Rd

19 (Date received by registrar) DEC 29 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26-47 19 , at 4.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-47 19 , to 12-26-47 19 , and that I last saw h[illegible] alive on 12-26-47 19

Immediate cause of death Terminal Bronchopneumonia. — Duration 1-2 yrs.

Due to Advanced arteriosclerotic Cardio Vascular Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. K. Gayle M. D.

Address 642 N. Eu Blvd Date signed 12-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G58472
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph's Hospital Dept.
(c) Hospital or institution: 87

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Bonhag

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Bonhag

6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) May 6 1871

8. AGE: Years 76 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Germany (City, county, and state)

10. Usual Occupation Retired

11. Industry or business Balto. T Mfg Co

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Anna Bonhag
(b) Address 2037 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-47 (month) (day) (year)

(c) Cemetery or crematory Emmanuel
Location Linden Ave. Balto. Md

18 (a) Funeral director John E. Milligan
(b) Address 2437 E. Oliver St

19 (a) DEC 29 1947 (Date rec'd by registrar) Huntington Northeastern Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20/1947 at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. L. Salvinski M.D.
Medical Examiner.
Date signed 12/27/47

VS 151

G58473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c ✓

Registered No. G58473

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9-1
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (~~year~~, ~~mos.~~, or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 Wyanoke Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES ALBERT NOLAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-07-2652

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of husband or wife Marie Nolan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-2-1895

8. AGE: Years 52 | Months 11 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B. & O. R. R.

FATHER 12. Name John Nolan

13. Birthplace Maryland

MOTHER 14. Maiden Name Louise Seibold

15. Birthplace Maryland

16 (a) Informant Mrs Katherine Howe

(b) Address 503 Wyanoke Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location 4330 Belair Rd

18 (a) Funeral director John L. J. Moran

(b) Address 3000 E. Baltimore St.

19 (a) DEC 29 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 28 1947, at 5:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1947, to 12-28 1947 and that I last saw him alive on 12-27 1947.

Immediate cause of death CARDIAC FAILURE — Duration .....

Due to RHEUMATIC HEART DISEASE. — Duration .....

Due to ..... — Duration .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature J. L. Moran Jr. M. D.

Address 1104 Law Bldg. Date signed 12-28-47

X

G58474 Dr Hartman Asl-2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

G58474 Registered No. 44606

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Simpson St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	married

6 (b) Name of husband or wife Naomi White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-26-20

8. AGE: Years	Months	Days	If less than one day
27 years	1	0	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Landon White
13. Birthplace
MOTHER 14. Maiden Name Sara Green
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 29/47 (month) (day) (year)
(c) Cemetery or crematory
Location Zion (Pikesville) Md.

18 (a) Funeral director Mrs. Lott A. Elliott & Dept
(b) Address 1129 N. Carolina St

19 DEC 29 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1947, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1947 to Dec 26 1947 and that I last saw him alive on Dec 26 1947

Immediate cause of death Pneumococcal (Type ?) Pneumonia RUL, RML
Due to Toxic Diffuse goitre

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —

of autopsy Pneumonia & goitre

Duration
1 day
2 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. E. Van Metre Sr M.D.
Address Johns Hopkins Hosp Date signed 12/27/47

X

G58475 LW 116075

BALTIMORE CITY HEALTH DEPARTMENT ✓ X

CERTIFICATE OF DEATH 139a

Registered No. G58475

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Crownsville State Hospital (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Jefferson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife 1910

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 37 ? | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Silas Murray
13. Birthplace ?

MOTHER
14. Maiden Name Emma Smith
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/30/47 (burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Kalmarock
Location Kalmarock Va

18 (a) Funeral director Geo. H. Kelson
(b) Address 1313 Pressman St

19 (a) [illegible] Registrar Hattie Lee Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24- 19 47 at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 19 47 to 12-24 19 47 and that I last saw h[illegible] alive on 12-24 19 47

Immediate cause of death Generalized peritonitis — Duration 2 wks

Due to pelvic abscess — 2 days

Due to P.I.D. — 9 yrs

Other Conditions Schizophrenia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gordon Craft, M.D.
Address Balt. City Hosp. Date signed 12/31/47

1-2-48 X

G58476 ✓ G58476

B.C. # A-97409

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

CERTIFICATE OF DEATH 161 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Payne Ave & Oakland St

(c) Hospital or institution: West Balto. General Hosp 27-15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 16 hrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5517 Matthild Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NORMAN CAMPTBELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-47

8. AGE: Years | Months | Days | If less than one day: 16 hr. 10 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name Norman Campbell

FATHER 13. Birthplace BALTO MD.

MOTHER 14. Maiden Name Geraldine Fitsche

MOTHER 15. Birthplace Baltimore Md.

16 (a) Informant Geraldine Campbell

(b) Address 5517 Matthild Ave.

17 (a) ~~Parkwood~~ Cemetery Parkwood (b) Date thereof 12-29-47 (month) (day) (year)

(c) Cemetery or crematory TAYLOR AVE

Location

18 (a) Funeral director Geo. H. Leimbach

(b) Address 528 N. Lynchburst St

19 (a) (b)

(Date received) (Registrar)

DEC 29 1947 Huntington Hillman (Deputy Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/47 19..., at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/47 19..., to 12/27/47, and that I last saw him alive on 12/23/47

	Duration
Immediate cause of death Respiratory failure	
Due to Erythroblastosis foetalis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C&W de Lang M. D.

Address WBGH. Date signed 12/27/47

X

G58477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G58477 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2634 Maenpla Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Strong

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Arthur H. Stevens
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 8, 1868

8. AGE: Years 79 | Months 7 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Carroll County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER 12. Name Basil Phillips
13. Birthplace Md.

MOTHER 14. Maiden Name Julia A. Bescraft
15. Birthplace Md.

16 (a) Informant Grace Hoffman
(b) Address 1811 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel County, Md.

18 (a) Funeral director George L. Stahl
(b) Address 2101 Frederick Ave.

DEC 29 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1947, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1947, to 12-27 1947, and that I last saw h.er alive on 12-27 1947.

Immediate cause of death Pneumonia
Circulatory Collapse
Due to Congestive Heart Failure
Due to Arteriosclerotic - Degenerative Cardiovascular Disease.
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney H. Sachs
Address Univ. Hosp. Date signed 12-28 1947 M. D.

937

G58478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58478 Registered No. 1317

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533W. Biddle St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3 (a) FULL NAME William Burkett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Salsbury, Md. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name William H. Burkett
13. Birthplace Salsbury, Md.

MOTHER
14. Maiden Name Alice
15. Birthplace Salsbury, Md.

16 (a) Informant Isabelle Burkett
(b) Address 1721 Division Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calavary
Location Brooklyn, Md.

18 (a) Funeral director Joesph L. Russ
(b) Address 1200 Mcculloh Street

19 (a) (b)

DEC 29 (Local registrar) Washington Wilkerson M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25/47 1947, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1947, to 12/25 1947, and that I last saw h[illegible] alive on 12/25 1947

Immediate cause of death: Hypertension Cardio Vascular - Renal disease — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Williams Garner M.D.
Address 1521 Division St Date signed 12/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58479 ✓ G58479 82a

Registered No.

G58479

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 634 S. Newkirk
(c) Hospital or institution: 26-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 634 S. Newkirk St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL C. GEORGE, JR.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 1907

8. AGE: Years	Months	Days	If less than one day
40	11	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Driller
11. Industry or business Ship Yard

FATHER
12. Name Paul C. George, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Cora M. Wilson
15 Birthplace Baltimore, Md.

16 (a) Informant Paul C. George, Sr.
(b) Address 634 S. Newkirk St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 29 47 (month) (day) (year)
(c) Cemetery or crematory Poplar Cemetery
Location Warren, Maryland

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe, St.

DEC 29 1947 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1947 to 12/26 1947 and that I last saw h. alive on 12/26 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas. T. Flomm X
Address 3 E S Eaut St Date signed 12-29-47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

195E

Registered No. G58480

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 67 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME HARRY STAUFFER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Estell Rockwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-3-1905

8. AGE: Years 42 | Months 9 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Steel worker

11. Industry or business —

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Estell Stauffer (wife)
(b) Address 1221 Gusryan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Frederick Ave.

18 (a) Funeral director Libby & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 (a) 12-29-1947 (Date received by Registrar) (b) Tuntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1947, at 8 p.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Empyema right pleural cavity
Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-9-47 at 9 a.m. M. 53-00
(b) Where did injury occur? Beth. Steel Co. Sps. Pt. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck in back steel girder

23. Signature [signature] M.D. (Medical Examiner)
Date signed 12-29-47

X

058481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 058481

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 S. Durham Street
(c) Hospital or institution: 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 S. Durham Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS J. KEISER, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clara
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) February 25, 1890

8. AGE: Years	Months	Days	If less than one day
57	10	2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Sprayer
11. Industry or business Furniture Mfg.

FATHER
12. Name Michael Keiser
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Lena Schmidt
15. Birthplace Germany

16 (a) Informant Mrs. Clara Keiser
(b) Address 513 S. Durham Street

17 (a) Burial (b) Date thereof 12/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 DEC 29 1947 (Huntington Williams M.D.)
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1947 at 8a.m. ed

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1947 to 12/27 1947
and that I last saw h alive on 12/26, 1947.

Immediate cause of death: Intestinal Obstruction — Duration: dent
Due to: Malignancy of Colon — 6 mo.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: June '47
Major findings of operation: Malignancy of Colon
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury
23. Signature
Address Date signed 12/28/47

G58482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G58482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 429 East Lorraine Avenue
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 E. Lorraine Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANTHONY SGARLATA

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Virginia Gerffie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
79	-	-	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Cabinet Maker
11. Industry or business

FATHER
12. Name Mario Sgarlata
13. Birthplace Italy

MOTHER
14. Maiden Name Rose (?)
15 Birthplace Ttaly

16 (a) Informant Mrs. John Lazzaro, Sr.
(b) Address 429 E. Lorraine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address 4435 4th

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/47 19 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 19 47 to Dec 27 19 47 and that I last saw h[illegible] alive on Dec 27 19 47.

Immediate cause of death	Duration
Carcinoma of Prostate	
Due to	
Due to	
Other Conditions Coronary occlusion (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Coffman M. D.
Address 4435 4th Date signed 12-29-47

VS 199

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. C58483

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. County
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Murdock Rd -12
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara V. Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years	Months	Days	If less than one day
92			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name ?
13. Birthplace Balto

MOTHER
14. Maiden Name Sarah Wright
15. Birthplace Ind

16 (a) Informant Virginia B. Tillman
(b) Address 611 Murdock Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Le Worth Co

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) DEC 9 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/47 19 at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1/47 19 to 12/26/47 19, and that I last saw h[illegible] alive on 12/26/47 19

Immediate cause of death	Duration
Fracture	
Due to Hypostatic pneumonia	
Due to general debility	
Other Conditions Fracture of Rt. Hip	

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12/8/47 at 11 A.M.
(c) Where did injury occur? 611 Murdock Rd. Balto. Co. Md.
(City or town)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Slipped and fell down stairs

23. Signature John White M.D.

Address Lutheran Hosp Date signed 12/29/47

End L Ryan Ind X

C58184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. C58184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 E. Barney St.
(c) Hospital or institution: 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 E. Barney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE YOUNG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John F. Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/17/1864

8. AGE: Years	Months	Days	If less than one day
83	-	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Family
(b) Address 114 E. Barney St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 12/31/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director Samuel L. McCauley
(b) Address 130 E. Fort Ave.

19 (a) [illegible] 1947 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1947, 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1946 to Dec 26 1947 and that I last saw h alive on Dec 26 1947.

Immediate cause of death	Duration
Acute dilatation of heart	2 ds.
Due to Edema of lungs	7 ds.
Due to Arteriosclerosis & Hypertension	Indef.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. E. Campbell M. D.
Address 164 S. Hilmore St. Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

C58485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓121

Registered No. C58485

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 W Franklin St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1931

8. AGE: Years 16 | Months 1 | Days 14 | If less than one day hr. 30 min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Kitchen Worker

11. Industry or business Restaurant

FATHER
12. Name John Holland
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Rosie Harris
15 Birthplace Baltimore. Md.

16 (a) Informant Hattie Johnson
(b) Address 713 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31, 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore city

18 (a) Funeral director Joseph A. Perry
(b) Address 661 W Lt Saratoga St

19 (a) DEC 29 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27-47 1947, at 12:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1947 to Dec. 27 1947, and that I last saw h. alive on Dec. 26 1947

Immediate cause of death	Duration
Ventricular Fibrillation	
Due to Ether Anesthetic	45 min.
Due to Status Lymphaticus	
Other Conditions Acute Suppurative Appendicitis	hours

(Include pregnancy within 3 months of death)

Date of operation 12-26-47

Major findings of operation: Acute Suppurative Appendicitis

of autopsy: Enlarged Thymus & Status Lymphaticus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/26/47 M
(c) Where did injury occur? Hospital (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No (Specify type of place)
(e) Means of injury Administration of ether

23. Signature Joseph Di Pino M. D.
Address Mercy Hosp Date signed 12-27-47
For A. J. K. Odom by Harold L. Wilson M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G58486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 A

G58486 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison ave
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 51

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Madison ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerry Bolden

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 2 1896

8. AGE: Years 51 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Jerry Bolden

13. Birthplace Baltimore Maryland

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Bertha Cole

(b) Address 920 Carrollton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30 1947 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery Location Baltimore City

18 (a) Funeral director Joseph A Sivley

(b) Address 66 West Lane Street

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/47 19 , at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15/47 to 12/26/47, and that I last saw h[illegible] alive on 12/26/47

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertensive Conditions

Due to: Hypertension

Other Conditions: Cirrhosis Bronchitis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Pasteuse M. D.

Address 526 N. Carey Street Date signed 12/27/47

VS 140

G58487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G58487

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Canton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 21st St N.W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Umstattd

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-25

8. AGE: Years 22 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation student

11. Industry or business

FATHER 12. Name William E. Umstattd

13. Birthplace Penn.

MOTHER 14. Maiden Name Dora Brunner

15. Birthplace Ohio

16 (a) Informant JOHNS HOPKINS HOSPITAL Records

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-30-47 (month) (day) (year)

(c) Cemetery or crematory NORTH LAWN

Location CANTON OHIO

18 (a) Funeral director John D. Mitchell & Son

(b) Address 1900 Easton Rd.

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION 90A

20. DATE OF DEATH Dec. 29 1947, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1947, to Dec. 29 1947, and that I last saw h[illegible] alive on Dec. 27 1947

Immediate cause of death	Duration
Due to Acute leukemia, type unknown	4 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hepatomegaly, splenomegaly

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H E Markley M. D.

Address Johns Hopkins Hosp. Date signed 12/29/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No. G58488

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3723 Fait Ave.
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3723 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA KIMMARLE

3 (b) If veteran, name war -----

3 (c) Social Security Account No. -----

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles W. Kimmarle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 8, 1868

8. AGE: Years 79 | Months 9 | Days 20 | If less than one day ....hr. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: House-Work

FATHER
12. Name: John Kreppel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Catherine Drommelhauser
(b) Address: 3723 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-47.
(month) (day) (year)
(c) Cemetery or crematory: Sacred Heart Cemetery
Location: 4701 German Hill Rd.

18 (a) Funeral director: Charles S. Zeiler.
(b) Address: 901 S. Conkling St.

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington for Williams M.D. Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1947, at 4:25 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 28 1947. and that I last saw h[illegible] alive on Dec 28 1947.

Immediate cause of death	Duration
Acute Cardiac Failure.	
Due to Cardio-Vascular Renal Disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: E. A. Flanagan M.D.

Address 3503 Fait Ave. Date signed 12-29-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 117B

Registered No. G58389

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~3219 Fleet Street~~

(c) Hospital or institution: Church Home Hospital 26 W

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 31 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore City

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3219 Fleet Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** George A. Kuhn JR.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-3193.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Dec~~ Feb 11 1916

8. AGE:	Years	Months	Days	If less than one day
	31	10	17 16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name George A. Kuhn SR.

13. Birthplace Maryland

MOTHER

14. Maiden Name Margaret Bleich

15. Birthplace Maryland

16 (a) Informant Deceased

(b) Address 3219 Fleet Street

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-30-47 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART CEM.

Location 4701 GERMAN HILL RD.

18 (a) Funeral director Charles S. Feiler

(b) Address 901 S. Conkling St.

19 (a) (Signature) (b) Huntington Woods Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27-47 1947 at 1 05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1947 to 12-28 1947 and that I last saw him alive on 12-28 1947.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to	
Due to	
Other Conditions Paralytic Ileus	5 days

Gastric Resection

(Include pregnancy within 3 months of death)

Date of operation 12-18-47

Major findings of operation: Duodenal Peptic Ulcer

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Henry B. Wilson M. D.

Address Church Home Hosp. Date signed 12-28-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58490

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution:
Home for the Aged and Poor 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Wylie Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Wagner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry Wagner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1871

8. AGE: Years 76 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER
12. Name John Hinkel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Connolly
15. Birthplace Baltimore

16 (a) Informant Mrs. Anna V. W. Snider
(b) Address 3006 Wylie Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City.

18 (a) Funeral director C. Vernon Lawrence.
(b) Address 4611 Park Heights Ave.

DEC 29 1947 (a) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1947, at 9:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947, to 12- 25 1947 and that I last saw h er alive on 12- 24 19 47.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic myocarditis	5 yrs
Due to	
Other Conditions Tuberc Sclerosis	6 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M.D. M. D.

Address 1631 E. North Ave. Date signed

VS 150

G58491

HEALTH DEPARTMENT—CITY OF BALTIMORE

G58491

CERTIFICATE OF DEATH 52a

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4731 Park Heights Ave ST. 27-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Alan BALSAM

(Residence in Baltimore: No. Baltimore, Md. St. 27 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: January 24, 1892 (Month) (Day) (Year)

7-AGE: 55 yrs. 11 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Trader in Public Stock
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Shamokin Pa

PARENTS

10-NAME OF FATHER: Fredrik Balsam

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Julia Krevatch

13-BIRTHPLACE OF MOTHER (State or country): Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edith Bertha O'Donnell

(Address) Ellicott City, Md.

15. Filed DEC 29 1947, 19... Huntington Williams, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 28, 1947 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1947, to Dec 28 1947, that I saw him alive on Dec 28, 1947, and that death occurred, on the date stated above, at 7:00 p.m.

The CAUSE OF DEATH* was as follows:

Hypernephroma (Cancer Kidney)

(Duration) ..... yrs. 10 mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) David I. Macht M. D.

Dec 26, 1947 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill Wash. Pk.

DATE OF BURIAL: 12/31, 1947

20-UNDERTAKER: Clarence P. Hoffman

ADDRESS: 1639 E. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 658192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette + Lexington Sts.
(c) Hospital or institution Franklin Square Hospital 11-27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 PARK AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Peter Lambert

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-01-5618

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife —
6 (c) If alive, give age 2 years
7. Birth date of deceased (mo., day, yr.) 1885
8. AGE: Years 62 Months — Days — If less than one day hr. min.
9. Birthplace Greece (Town, county, and state)
10. Usual Occupation
11. Industry or business Restaurant Business

FATHER
12. Name Lambros Lambert
13. Birthplace Greece

MOTHER
14. Maiden Name Martha Alexandoules
15. Birthplace Greece

16 (a) Informant George Agnew
(b) Address 39 Murdock Road

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)
(c) Cemetery or crematory GREEK ORTHODOX
Location Y EVANGELISMOS

18 (a) Funeral director Geo. L. Agnew Funeral Home Inc
(b) Address 116 N. Mt. Royal Ave.

19 (a) DEC 29 1947 (b) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25- 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1947 to 12/25 1947, and that I last saw him alive on 12/25 1947

Immediate cause of death	Duration
Terminal Pneumonia	
Due to Bronchopneumonia Rt Lung, Marked	
Due to	
Other Conditions Arteriosclerotic Cardio Renal Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Pneumonia Rt Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R Ramsey M. D.
Address 7 Hollen Sq Date signed 12/29/47

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G58193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 Whittier ave.
(c) Hospital or institution: 154
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Whittier avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME STYLIANOS APERGE

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Melpomene Aperge
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1895

8. AGE: Years	Months	Days	If less than one day
52	1	--	....hr. ....min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Restauranteur
11. Industry or business

FATHER
12. Name Arestedes Aperge
13. Birthplace Greece

MOTHER
14. Maiden Name Angelica unknown
15. Birthplace Greece

16 (a) Informant Melpomene Aperge
(b) Address 2002 Whittier ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/47 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Evangelismos

18 (a) Funeral director Geo. S. Agnew Funeral Home Inc.
(b) Address 1819 N. Mt. Royal Ave

19 (a) 12-29-1947 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to Dec 23 1947, and that I last saw him alive on Dec 23 1947.

Immediate cause of death	Duration
Acute Cardiac Dilatation	One day
Due to Hypertensive Cardiovascular Renal disease	3 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Lafayette St Date signed Dec 29

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58494

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N.Carey Street
(c) Hospital or institution: God Lavarita Home 86
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 1537 N.Caroline St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James T. Halpin

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3rd 1859

8. AGE: Years 88 | Months 4 2 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired Printer
11. Industry or business

FATHER
12. Name Timothy Halpin
13. Birthplace Baltimore

MOTHER
14. Maiden Name Don't know
15. Birthplace Don't know

16 (a) Informant Mrs Mary L.Smith
(b) Address 1537 N.Caroline Street

17 (a) Burial (Burial, [redacted]) (b) Date thereof Dec 30-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W Mt. Royal Ave

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1947, at 9h M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1947 to Dec 27 1947. and that I last saw h.e alive on Dec 27 1947.

Immediate cause of death: Acute Cardiac Dilitation — Duration 2 days

Due to: Cardiac Arterio Sclerosis — Duration 2

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Lafayette Ave Date signed Dec 29

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 170c

G58495 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Martinsburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 E. Burke (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DORIS PRICE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph C. Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1946

8. AGE: Years	Months	Days	If less than one day
21	3	19	hr. 26 min.

9. Birthplace Martinsburg, Bukilu, W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name C. W. Youngblood
13. Birthplace West Virginia

MOTHER
14. Maiden Name Mary Ambrose
15. Birthplace West Virginia

16 (a) Informant C. W. Youngblood
(b) Address Martinsburg, W. Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-29-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Martinsburg W Va

18 (a) Funeral director H. C. Fightmaster
(b) Address Ellicott City Md.

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Thurston E. Williams, Md. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1947, at 9.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Petechial hemorrhages of brain
Lacerations and contusions of head.
~~Due to~~ Atelectasis left lower lung
Left pleural effusion.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-24-47 at 8 p. M.
(b) Where did injury occur? Martinsburg, W. Va.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger- collision with auto

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 12-29-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

G58496 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. W-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D&A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 160 Thomas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche STUDZINSKI

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward Adam
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Dec 14, 1907

8. AGE: Years	Months	Days	If less than one day
37 34	11	23	hr. min.

9. Birthplace Roanoke - Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel S. Cunningham
13. Birthplace Fort Monroe, Va

MOTHER
14. Maiden Name Blanche Watson
15. Birthplace Fofhill, Va

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 22 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 29 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6, 1947 at 6a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to illuminating gas.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-6-47 at 9 A M
(b) Where did injury occur? 1610 Thomas Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhalation of illuminating gas

23. Signature George P. Merkel M.D. (Medical Examiner)
Date signed 12/6/47

VS 151

G58497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. G58497

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204- Hollins St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME JAMES McDONALD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
53			....hr. ....min.

9. Birthplace..... (Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace Unknown

16 (a) Informant Unknown
(b) Address

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School DEC 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 DEC 29 1947 (Date rec'd by registrar) (b) Houston for Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 19 47 at 12.30 P M

21. I certify that I took charge of the remains described above, held an inquest in.....thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Arteriosclerotic cardio-vascular disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G58498
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Beal Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary V. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
89			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School DEC 22, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1947 at 12 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Thomas M.D.
Medical Examiner.
Date signed 12-17-47

G58199 Baltimore G58199

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

BALCHUNAS 47

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Good Samaritan
(c) Hospital or institution: V. H. Carey St. 208
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 S. Augusta Ave (If rural, give location)
(e) Citizen of foreign country? Lith. (Yes or No)
If yes, name country Lithuania

3 (a) FULL NAME Adam Balchunas

3 (b) If veteran, name war None. | 3 (c) Social Security Account No. None

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Victoria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1885

8. AGE: Years 62 | Months — | Days — | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Miner
11. Industry or business Lindsey Coal Co.

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant John Balchunas
(b) Address 118 S. Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Beloit Rd.

18 (a) Funeral director Clark W. Lachenmeyer
(b) Address 703 McHenry St.

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1947. at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1947. to Dec 26 1947. and that I last saw h[illegible] alive on Dec 26 1947.

Immediate cause of death: Carcinoma of Lung — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Glassman M. D.
Address 753 W. Fayette St. Date signed Dec 29 1947

G58500
AS-95-12

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 1516

Registered No. G58500

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Michigan (b) County
(c) City or town Pontiac, (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 S. Jessie St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christine Anne Everett
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-19-47
8. AGE: Years | Months: 5 | Days: 9 | If less than one day: hr. min.
9. Birthplace Michigan (town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Royce Everett
13. Birthplace Mich.
14. Maiden Name Jeannene Sheppard
15. Birthplace Mich

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/29/47 (month) (day) (year)
(c) Cemetery or crematory Batavia, Mich
Location Michigan
18 (a) Funeral director W. A. Cook Sons
(b) Address St. Paul & Preston Sts
19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Registration No. Hollins, 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 - 1947 at 2:45 A.M.
21. I certify that death occurred on the date above stated, that I attended deceased from 12-11- 1947 to 12-28-1947 and that I last saw h.. alive on 12-28-1947
Immediate cause of death BILE PERITONITIS — Duration
Due to POST-OPERATIVE RECONSTRUCTION OF
Due to CONGENITAL BILIARY ATRESIA & COMPLETE EXTRA HEPATIC
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William A. Sparrow
Address Johns Hopkins Hospital
Harold Jones

G58501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58501 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 27-B
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Beechdale Rd. (If rural, give location)
(e) Citizen of foreign country? No (Answer Yes or No)
If yes, name country —

3 (a) FULL NAME Robert Marvin Wallace

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marion Dell Wallace
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1885

8. AGE: Years 62 | Months 4 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Philadelphia, Penn. (Town, county, and state)

10. Usual Occupation Glen L. Martin Co.

11. Industry or business

FATHER
12. Name William Wallace
13. Birthplace Penn.

MOTHER
14. Maiden Name Augnes Glossy
15. Birthplace Penn.

16 (a) Informant Mrs Marion D. Wallace (wife)
(b) Address 2 Beechdale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-47 (month) (day) (year)
(c) Cemetery or crematory Green Cemetery
Location Woodbury, N.J.

18 (a) Funeral director J. Livaudais Sons Inc.
(b) Address 108 W. Mt. Royal Ave.

19 (a) 12/29/47 (Date rec'd by registrar) (b) ... Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1947, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1947 to Dec. 28 1947 and that I last saw him alive on Dec. 28 1947.

Immediate cause of death: Massive Cerebral Hemorrhage — 4 hrs.
Due to essential Hypertension — 10 yrs.
Due to ...
Other Conditions ...
(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operations: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...

23. Signature Thos. R. Freeman M. D.
Address Union Memorial Hosp. Date signed Dec 28, 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

✓ G58502 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dennison Street
(c) Hospital or institution: Crawford Retreat 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME HARRY CLAY BIRMINGHAM

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Katherine S. Birmingham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 4 1868

8. AGE: Years	Months	Days	If less than one day
79	11	24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Balto. Police Dept.

FATHER
12. Name James Birmingham
13. Birthplace North Carolina

MOTHER
14. Maiden Name Laura V. Richter
15. Birthplace Annapolis, Md.

16 (a) Informant Mrs. Lawrene A. Smith (daughter)
(b) Address 2541 W. Lafayette Ave., City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec/31/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City.

19 (a) 1/2/24/48 (Date rec'd by registrar) Washington for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1947, at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1947 to Dec 28 1947 and that I last saw h[e] alive on Dec 28 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Renal Disease	3 wks
Due to Generalized arteriosclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert Richter
Address 2302 Edmondson Ave Date signed 12/29/47 M. D.

VS 150

G58503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59B

Registered No. G58503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Cathedral
(c) Hospital or institution: Severn Apts 11-7

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Cathedral
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Edward Hunter Norman

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna M. Norman
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Nov 8 1861

8. AGE: Years 86 | Months 1 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Washington Co. N.C.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business none

FATHER
12. Name Wm. J. Norman
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Nicholson
15. Birthplace N.C.

16 (a) Informant Mrs A. M. Norman (wife)
(b) Address 701 Cathedral St

17 (a) Burial (b) Date thereof 12-30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Schwaab Bros Co.
(b) Address 1084 W North Ave.

19 (a) ____ (b) ____
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28, 1947 at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1942 to Dec 28 1947 and that I last saw him alive on Dec 24 1947

Immediate cause of death: Arteriosclerosis and senile degenerative changes — Duration: 4 years
Due to: Atherosclerosis
Due to: ____
Other Conditions: Hypertension arthritis advanced senile vascular changes
(Include pregnancy within 3 months of death)
Date of operation: ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature John A. Luetcher M. D.
Address 12 E. Eager St Date signed Dec 29/47

VS 150

97

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

658504 B.C. Hy-97286 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. 658504

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hospital for
(c) Hospital or institution: Women of Md 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 S. Decker Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Jenkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-20-47

8. AGE: Years | Months | Days | If less than one day 15 hr. min.

9. Birthplace Baltimore. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Wesley John Jenkins

13. Birthplace Baltimore. Md

MOTHER 14. Maiden Name Catharine Ann Jenkins

15. Birthplace Baltimore. Md

16 (a) Informant Mr. Wesley J. Jenkins

(b) Address 13 S. Decker Ct. Balto 24 Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School DEC 22 1947

18 (a) Funeral director Commissioner of Health

(b) Address

DEC 29 1947 (Date rec'd by registrar) Hutchinson Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/47 19 , at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20/47 19 , to 12/21/47 19 , and that I last saw h.e.r. alive on 12/21/47 19 .

Immediate cause of death Prematurity — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. J. Dempsey Jr. M.D.

Address Women Hospital Date signed 12/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G58505
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Harvey St.
(c) Hospital or institution: 24-W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Harvey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Hudson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Cecelia Hudson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8-1876

8. AGE: Years	Months	Days	If less than one day
71	2	19	hr. min.

9. Birthplace Ellicott City Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER 12. Name David Hudson
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant William B. Hudson
(b) Address 700 Harvey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) DEC 29 1947 (Date rec'd by registrar) (b) Registrar [illegible]

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1947, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to 12/27 1947, and that I last saw him alive on 12/27 1947.

Immediate cause of death	Duration
Coronary occlusion	3 yrs.
Due to Hypertensive Heart Disease	15-20yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Max Baums M. D.
Address 1501 N. Milton Ave Date signed 12/29/47

G58506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
Twilight Nursing Home 262
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4619 Frankford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar L. Fallon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1876

8. AGE: Years	Months	Days	If less than one day
71	1	6	hr. min.

9. Birthplace Frederick, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John B. Fallon
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Schill
15. Birthplace Md.

16 (a) Informant Miss Cora A. Fallon
(b) Address 4619 Frankford Avenue

17 (a) Burial (b) Date thereof 12-30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. John's
Location Frederick

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 DEC 30 1947 Huntington Williams M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1947 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1947 to Dec 27 1947, and that I last saw h~~im~~ alive on Dec 27 1947.

Immediate cause of death	Duration
Chronic myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. H. Cutterman M. D.
Address 2324 Reisterstown Rd Date signed 12/29/47

X

G58507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G58507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3003 Abell Ave.
(c) Hospital or institution: 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Abell Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nettie G. Edie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife James A. Edie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1870

8. AGE: Years	Months	Days	If less than one day
77	9	17	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown Christ
13. Birthplace Unknown

MOTHER
14. Maiden Name Sadie Unknown
15. Birthplace Pennsylvania

16 (a) Informant Mrs. W. M. Elliott
(b) Address 3003 Abell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 30 1947 (Date received by registrar) (b) Frederick Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 12/27 1947 and that I last saw her alive on 12/28 1947.

Immediate cause of death	Duration
Carcinoma Cervix	5 Yrs
Due to Diffuse Abdominal	
Due to Involvement	
Other Conditions Vesico Vaginal Fistula	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1020 Cleveland Ave. Date signed 12/29/47

G58508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G58508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 Parkmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Mrs. Sarah Ecker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Raymond Ecker
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) MAY 13, 1895

8. AGE: Years	Months	Days	If less than one day
52	7	16	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housf.
11. Industry or business

FATHER
12. Name David Ford
13. Birthplace —

MOTHER
14. Maiden Name Lana Dash
15. Birthplace —

16 (a) Informant Raymond Ecker
(b) Address 4364 Parkmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) DEC 30 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

V S 150 -A-A

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1947 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 1947 to 12-29 1947, and that I last saw her alive on 12-29 1947

Immediate cause of death BRONCHO PNEUMONIA — Duration

Due to

Due to

Other Conditions ADIPOSIS DOLOROSA · HYPERTENSIVE CVD
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May
Address 1400 N. Caroline St Date signed M. 12 D. 27 47

107

G58509N.

BALTIMORE CITY HEALTH DEPARTMENT

116060 CERTIFICATE OF DEATH

Registered No. G58509

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Maryland

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Crownsville State Hospitals
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Jordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6th, 1910

8. AGE: Years	Months	Days	If less than one day
37	1	20	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ? Geo. W. Brescal
13. Birthplace ? Maryland

MOTHER
14. Maiden Name ? Sarah Watts
15. Birthplace ? Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-47 (month) (day) (year)
(c) Cemetery or crematory Zion
Location Leonardtown Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

DEC 30 1947 (Date rec'd by registrar) Initials of Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26th 1947, at 1.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22/ 1947 to Dec 26 1947 and that I last saw her alive on Dec. 26 1947

	Duration
Immediate cause of death Resp. failure	
Due to Basilar meningitis	4 days
prob. pneumococcic	
Due to	
Other Conditions Broncho pneumonia	45 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: [illegible]
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. V. Crosby M.D.
Address Balto City Hosp. Date signed 12/29/47

81a

C58510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

C58510
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Ave.
(c) Hospital or institution: Colonial Nursing Home 28-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4504 Frederick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY BIRKENSTOCK

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of ~~husband~~ wife Nellie M. Birkenstock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1863

8. AGE: Years	Months	Days	If less than one day
84	0	28	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Butcher - Retired
11. Industry or business

FATHER
12. Name Henry Birkenstock
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Schott
15. Birthplace Germany

16 (a) Informant Miss Hazel Birkenstock
(b) Address 4504 Frederick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/47 (month) (day) (year)
(c) Cemetery Westminster Cem
Location Westminster, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) DEC 30 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9-1946 19 to 12-28- 1947, and that I last saw h~~im~~ alive on 12-28- 1947.

Immediate cause of death	Duration
Chronic Myocarditis	1 week
Due to Arteriosclerosis	
Due to	
Other Conditions Chronic nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Benj. B. Nunes, M.D. M. D.
Address 448 N. Kingsway Date signed 12-30-47

VS 150

937

C58511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C58511

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette St
(c) Hospital or institution: Franklin Square Hospital 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Ryan Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie (Lazzio) LANZIO

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Antonio

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23 1886

8. AGE: Years	Months	Days	If less than one day
61	9	6	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mr Frank Nemec
(b) Address 911 Ryan Street

17 (a) Burial (b) Date thereof 12/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 3801 Frederick Rd.

18 (a) Funeral director John J. Conway Jr.
(b) Address 901 & 903 Hollins St

19 (a) DEC 30 1947 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 191 4-48

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29th 1947, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12/29/47

X

G58512 2d Num BC HF 1.42 — 16833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58512 Registered No. 19724

161 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 N Fulton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Carol Paige

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-18-47

8. AGE: Years	Months	Days	If less than one day
		9/10	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Paige
13. Birthplace Virginia

MOTHER
14. Maiden Name Estelle Wills
15. Birthplace Maryland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Date, Lot

18 (a) Funeral director William A. Jackson
(b) Address 914 Pennsylvania Ave

19 DEC 30 1947 (Date rec'd by registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1947, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1947 to 12-28 1947, and that I last saw him alive on 12-28 1947.

	Duration
Immediate cause of death Aspiration with respiratory failure	8 hrs.
Due to Jaundice - Hepatolenticular	9 days
Due to R. Cirrhosis	6 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Cuyler, Jr. M. D.
Address Johns Hopkins Hosp. Date signed 12-30-47

G58513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G58513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. & Slat St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Collins
(If outside city or town limits, write RURAL and give town)
(d) Street No. RFD #1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Budd E. Cherry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife May Thomsen Cherry

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) May 6, 1896

8. AGE: Years 51 | Months 7 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Norwalk, Ohio
(Town, county, and state)

10. Usual Occupation Seafarer

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Etta ?
15 Birthplace ?

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-47 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Balto. Md.

18 (a) Funeral director E Haworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) (Date rec'd by registrar) (b) Number

VS 159

MEDICAL CERTIFICATION P

20. DATE OF DEATH Dec. 24 1947, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1947, to Dec. 24 1947, and that I last saw him alive on Dec. 24 1947.

Immediate cause of death	Duration
Brain abscess, parietal and temporal lobes, right side	UNKNOWN
Due to	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G58514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G58514 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sarento Ave
(c) Hospital or institution: Colonial Nursing Home 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 W. Camden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DOMINIC DEFINA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Marie Defina

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Aug. 3rd 1877

8. AGE: Years	Months	Days	If less than one day
70	4	10	hr. min.

9. Birthplace Palermo Italy (Town, county, and state)

10. Usual Occupation Fruit business

11. Industry or business

FATHER
12. Name Gaetano Defina
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine —
15. Birthplace Italy

16 (a) Informant Wm. E. Gilbert
(b) Address 2119 Old Frederick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave

19 (a) Dec 30 1947 (Date received by Registrar) (b) Huntington-White Residence

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1947, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1947 to 12/27 1947, and that I last saw him alive on 12/27 1947

	Duration
Immediate cause of death Carcinomatosis	5 mos
Due to Carcinoma of Stomach	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nicholas Defina M. D.
Address 244 N. Milton Ave Date signed 12/29/47

G58515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G58515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 West Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gerald DONAHUE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 - 1893

8. AGE: Years 54 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Bernard Donahue
13. Birthplace Ireland

MOTHER
14. Maiden Name Emma —
15. Birthplace —

16 (a) Informant Rachael G. Donahue
(b) Address 1622 Ashburton St

17 (a) Burial (b) Date thereof Dec 31-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Robt B. M. Walter
(b) Address 1401 Druid Park Dr

19 DEC 30 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION 3c

20. DATE OF DEATH December 27, 1947, at 12 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/29/47

G58516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G58516 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3704 Dorchester Road
(c) Hospital or institution: none 20-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Monastery Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Harry D. Poor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Eleanora M. Poor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1852

8. AGE: Years 95 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Elliott O'D. Poor
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary A. Stewart
15. Birthplace Va.

16 (a) Informant Amelia E. Sykes
(b) Address 3704 Dorchester Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/47 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 DEC 30 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1947, at 3 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1947 to Dec 27 1947 and that I last saw h alive on Dec 27 1947

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to Senile Myocarditis	6 mos
Due to Arteriosclerosis	4 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Sons
Address 826 [illegible] Date signed 12/30/47 M.D.

VS 150

T58517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 44 B

G58517
Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 Broadway Balto.
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) None

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Rural, Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Magnolia Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Neisser

3 (b) If veteran, name war: W.W. II
3 (c) Social Security Account No. 217-01-4915

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs Dorothy Neizzer
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 18 1918

8. AGE: Years 29 | Months 1 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Arthur Neizzer
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Spencer
15. Birthplace Maryland

16 (a) Informant Patient before Death
(b) Address 301 Magnolia Terrace Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co

18 (a) Funeral director J. Bruce Jenkins
(b) Address 1405 E. Eutaw St Bal

19 (a) DEC 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Nov~~ 12-28 1947, at 3:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1947, to 12-28 1947, and that I last saw him alive on 12-22 1947.

	Duration
Immediate cause of death: Cardiorespiratory Failure	terminal
Due to: Hodgkin's Disease	approx. 1 mo.
Due to:	
Other Conditions: Laparotomy	

(Include pregnancy within 3 months of death)
Date of operation 12-23-47
Major findings of operation: Hodgkin's
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry B. Wilson M. D.
Address Church Home Hosp. Date signed 12-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 658518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 Battery Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vivian Crowe

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-12-6813

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 11-1923

8. AGE: Years	Months	Days	If less than one day
24	10	17	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation MACHINE ATTENDENT

11. Industry or business AMERICAN SUGAR REFINERY

FATHER
12. Name CLYDE B. CROWE
13. Birthplace VIRGINIA.

MOTHER
14. Maiden Name JESSIE E WILSON
15. Birthplace BALTIMORE MD

16 (a) Informant CLYDE B. CROWE.
(b) Address 1221 BATTERY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 1 1948 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location A A Co

18 (a) Funeral director Bernard C Hartz
(b) Address 121 E West St

19 (a) DEC 30 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1947, at 3 p. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain
Homicidal pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-14-47 at 1 a. M.
(b) Where did injury occur? 319 W. Franklin St (Tavern) Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Earl L Penny M.D. (Medical Examiner)
Date signed 12-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1408

Registered No. 058519

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) D. O. A

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 759 Mc Henry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Ottey

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-14-7609

4. Sex: FEM | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife WALTER A OTTEY

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) DEC 24 1915

8. AGE: Years	Months	Days	If less than one day
32	0	4	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business STANDARD TAILORING Co.

FATHER
12. Name THOMAS ORLOWSKI
13. Birthplace Md.

MOTHER
14. Maiden Name MARY SCHWARTZ
15. Birthplace BALTIMORE MD

16 (a) Informant WALTER R COTTEY
(b) Address 759 Mc HENRY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 31-47 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location A A Co

18 (a) Funeral director Bernard G Harlow
(b) Address 121 E West St

DEC 30 1947 (Date rec'd by registrar) Washington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

DATE OF DEATH 12/29 1947, at 10:15 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry (Autopsy, Inspection or Inquiry), find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary embolism - due to Incomplete abortion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L Rupp M.D. Medical Examiner
Date signed 12/29/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 058520

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 792 W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) D.O.A.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 792 W Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Mae Hunter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Hunter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1900

8. AGE: Years 47 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Thomas Robinson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mollie
15. Birthplace Balto. Md.

16 (a) Informant Rose Fisher
(b) Address 792 W. Mulberry St.

17 (a) Burial (b) Date thereof Dec. 31-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

DEC 30 1947 (b) Hamilton for Williams
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1947, at 6 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl A. Royer M.D.
Medical Examiner.
Date signed 12-29-47

X

G58521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G58521

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3418 GLENMORE AVE.
(c) Hospital or institution: BALTO. 14, MD. 2-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3418 Glenmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH M. KARL

3 (b) If veteran, name war --

3 (c) Social Security Account No. 216-01-1441

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dorothy Karl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1903

8. AGE: Years	Months	Days	If less than one day
34	0	14	hr. 9 13 min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Glenn L. Martin

FATHER
12. Name Geo. J. Karl Sr.
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Schlee
15. Birthplace Balto. Md.

16 (a) Informant Dorothy Karl
(b) Address 3418 Glenmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) DEC 30 1947 (Date rec'd by Registrar) (b) Huntington, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 DEC 1947, at 6 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 SEPT 1947 to 29 DEC 1947, and that I last saw h.. alive on 29 DEC 1947.

Immediate cause of death	Duration
LOBAR PNEMONIA	
BILATERAL; HEPATIC INSUFFICIENCY	
PORTAL OBSTRUCTION.	
Due to METASTATIC ADENO-CARCINOMA	1½
Due to ADENOCARCINOMA OF RECTUM	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 24 SEPT 47
Major findings of operation: ADENO-CARCINOMA OF RECTUM.
of autopsy: NOT DONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Smith M.D.
Address 1127 N. Paul St. Date signed 29 Dec 47

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 058522

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 15-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollis Wakefield

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant John B. Jones
(b) Address 1707 Lemmon St

17 (a) Burial (b) Date thereof 12/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1803 Presstman St

19 (a) DEC 30 1947 Washington, D.C.
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1947 at 3 a.m.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12-26-47

C58523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. C58523

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai
(c) Hospital or institution: Mount Hope 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 No Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Tabachnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Claza
15. Birthplace Russia

16 (a) Informant Samuel Tabachnick
(b) Address 122 No Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

DEC 30 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1947, at 10 ff M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1947 to 12-29 1947, and that I last saw h.e.R. alive on 12/28 1947

Immediate cause of death	Duration
Arteriosclerotic Cerebro-vascular disease	2 1/2 yrs.
Due to Apoplexy	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lewis Blum, M.D. M. D.
Address 2310 Eutaw Place Date signed 12/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C58524

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 Tyson at
(c) Hospital or institution No 113
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Tyson at (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Turpin
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex female | 5. Color or race col. | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Nathaniel Turpin
6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr.) June 6th 1872

8. AGE: Years 75 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Prince Anne Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nathaniel Turpin
13. Birthplace Princess Anne, Md.

MOTHER
14. Maiden Name Mary Ballet
15. Birthplace Princess Anne Md

16 (a) Informant George S. Turpin
(b) Address 515 Brune at

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director Jos. Holzfaed
(b) Address 918 Druid Hill Ave.

DEC 30 1947 (Date rec'd by registrar) (b) Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1947, to Dec 27, 1947, and that I last saw her alive on Dec 27, 1947.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arteriosclerosis

Due to senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. B. Scott M. D.
Address 3524 Ft. Biddle Date signed 12-29-47

X 7

G58525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G58525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1132 Pennsylvania Ave
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha Reese

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Jeremiah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Woody
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Jeremiah Reese
(b) Address 1132 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 DEC 30 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1947, at 11 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1947 to 12/28 1947, and that I last saw h[illegible] alive on 12/28 1947.

Immediate cause of death Carcinoma of Liver — Duration 10 mos
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Trauberman M. D.
Address 1424 Eee Date signed 12/30/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G58526

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1158 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALEXANDER BASS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Estella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Durham County, N. C.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Sidney Bass
13. Birthplace Durham County, N. C,

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Major Bass
(b) Address 1158 N. Carey St.

17 (a) Burial (b) Date thereof Unknown
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Durham N.C.
Location Durham, N.C.

18 (a) Funeral director Joesph L. Russ
(b) Address 1200 McCulloh Street

19 (a) DEC 29 1947 (b) [illegible] M.D.
Date received Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1947, at 7.55 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, probably accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSE OF DEATH
Fractured pelvis
Fractured ribs
Due to Fractured neck of rt. femur
Intra-abdominal hemorrhage

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-27-47 ? 10 a.m. 16/2 M.
(b) Where did injury occur? 1158 N. Carey St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell out window

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed 12-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C58527.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C58527.

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Home 110 Calhoun St.
(c) Hospital or institution: Franklin Sq. Hosp. L-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 East Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brocato, Eda

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 Months Days If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Hus.

11. Industry or business

MOTHER / FATHER

12. Name Richard Guarnera

13. Birthplace Italy

14. Maiden Name ?

15. Birthplace Italy

16 (a) Informant Mrs. Minnie Pete Nee

(b) Address 602 St Stephens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2-1947 (month) (day) (year)

(c) Cemetery or crematory Most Holy Redeemer Cem

Location 3300 Belair Road

18 (a) Funeral director Joseph Lazar Inc.

(b) Address 201 E. Lexington St

19 (a) (Local registrar) (b) Huntington Hillsboro Md. (Registrar)

DEC 30 1947

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/47 19 . at 9 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1947 to 12/29 1947.
and that I last saw h[illegible] alive on 12/29 1947

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. A. Cacace M. D.

Address Franklin Square Hosp. Date Dec 29 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658528

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Winchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 3
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Copp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-23-47

8. AGE: Years | Months | Days 7 6 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and State)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Harry Woodrow Copp
13. Birthplace W. Va

MOTHER 14. Maiden name Kathleen Hagueflick
15. Birthplace Va

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 1/1/48 (month) (day) (year)

(c) Cemetery or crematory Mt Hebron
Location Winchester Va.

18 (a) Funeral director John O Mitchell & Son.
(b) Address 400 Eastern Ave

19 (a) DEC 30 1947 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1947 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1947 to Dec 29 1947 and that I last saw h alive on Dec 29 1947

	Duration
Immediate cause of death Respiratory - Cardiac failure	
Due to Congenital heart disease (Tetralogy of Fallot)	5 days
Due to Esophageal atresia with Trachea-esophageal fistula	7 days
Other Conditions Operation for repair of esophagus.	

(Include pregnancy within 3 months of death)

Date of operation 12-25-47

Major findings of operation: Esophageal atresia and trachea-esophageal fistula

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Engle Jr. M. D.
Address The Johns Hopkins Hosp. Date signed 12-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

A58529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C58529

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 223 MALLOW HILL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 4
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 MALLOW HILL
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN M LATCHFORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife late JOHN A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 7, 1880

8. AGE: Years 67 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name WILLIAM N JOYCE
13. Birthplace MD.

MOTHER
14. Maiden Name KATHERINE FLYNN
15. Birthplace IRELAND

16 (a) Informant MR JOHN A LATCHFORD
(b) Address 223 MALLOW HILL

17 (a) BURIAL (b) Date thereof JAN 2 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry H Weitzel Jr
(b) Address 4101 Edmondson Ave

19 (c) DEC 30 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 29 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1938 to 12/29 1947 and that I last saw h alive on 12/29 1947

Immediate cause of death, Hypostatic Pneumonia
Terminal
Due to Cerebral Hemorrhage
"
Due to General Arteriosclerosis & Hypertension

Duration
1 day
11/47 to 12/29/47
28 Yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin W. Johnson M. D.
Address 3432 Druid Park Ave Date signed

G58530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58530

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 N. Augusta Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 29 (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Augusta Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph E. McGuirk

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Helen B. McGuirk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1877

8. AGE: Years 70 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Barnard McGuirk
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Fitzpatrick
15. Birthplace Ireland

16 (a) Informant Mae Dunn - niece
(b) Address 606 Grantley street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Avenue

19 (a) DEC 30 1947 (Date rec'd by registrar) (b) [illegible] (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/47 19 ..., at 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17 1946, to Dec. 29, 1947, and that I last saw him alive on Dec. 29, 1947

Immediate cause of death	Duration
Renal failure	3 days
Due to Arteriosclerotic-cardio vascular-renal disease	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Kemp M. D.
Address 3030 Edmondson ave Date signed 12/30/47

BC 5-96808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 658531

658531

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3219 MASSACHUSETTS AVE
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 6
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 MASSACHUSETTS AVE.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME BABY NEMES

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 16 DEC., 1947

8. AGE: Years	Months	Days	If less than one day
—	—	—	1 hr. min.

9. Birthplace BALTIMORE, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name JOHN NEMES
13. Birthplace DUNLOP, W. VA.

MOTHER
14. Maiden Name ANN MASTERS
15. Birthplace CLARKSBURG, W. VA.

16 (a) Informant JOHN NEMES
(b) Address 3219 MASSACHUSETTS AVE

17 (a) MORGUE (b) Date thereof 17 DEC. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 22 1947
Commissioner of Health

18 (a) Funeral director
(b) Address 1432 W. N
(c) DEC 30 1947 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 19 47 to 12/16 19 47.
and that I last saw h.er alive on 12/16 19 47.

Immediate cause of death: Prematurity - 25 wks. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Christian J. Peeler

Address 1200 ST. Paul. Date signed 12/17/47

VS 150

MORGUE

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C585328 C 4-9694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓161a

Registration No. C58532

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 601 N. Boradway
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 North Dallas Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Surles (377224)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/10/47

8. AGE; Years	Months	Days	If less than one day
0	0	0	7 hr. 5 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name S. M. Price
13. Birthplace Unknown

MOTHER
14. Maiden Name Dosie Lee Surles
15. Birthplace North Carolina

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School DEC 17, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 20 1947 (Date rec'd by registrar) (b) Hundley for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1947, at 12:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10th 1947, to Dec. 10th 1947, and that I last saw her alive on Dec 10th 1947.

Immediate cause of death ? Asphyxia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ben C. Williams M. D.
Address The Johns Hopkins Hospital Date signed 12-11-47

G58533 Anatomical B.C. 9572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G58533

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 McElderry St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME (baby) Eloise Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	child

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-5-47

8. AGE: Years | Months | Days 10 days | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Ed
13. Birthplace.....

MOTHER
14. Maiden Name Eloise Rice
15. Birthplace Md.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical School DEC 18 1947

18 (a) Funeral director.....
(b) Address.....

19 DEC 30 1947 (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1947, at 9.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1947 to Dec 15 1947, and that I last saw her alive on Dec 15 1947

Immediate cause of death Asphyxia Caused by Premature Birth

Due to Prematurity

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature [signature] M.D.

Address Johns Hopkins Hosp. Date signed 12-18-47

VS 150

G58534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G58534

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 F
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Spellman Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/17/47

8. AGE: Years | Months | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Wood
13. Birthplace Va

MOTHER
14. Maiden Name Thomas Josephine
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School DEC 19 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 20 1947 (Date rec'd by registrar) (b) Hunting Jon Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1947, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Intracranial hemorrhage — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clifton Clinton Jr
Address Johns Hopkin Hosp Date signed 12-19-47

B.C.# 96812

G58533

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G58535
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 W. Lexington St
(c) Hospital or institution: 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 W. Lexington St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Boy Terry

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1947

8. AGE: Years | Months | Days | If less than one day 4 hr. 30 min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Luther N. Terry
13. Birthplace Charlottesville Va.

MOTHER
14. Maiden Name Edna M. Honeycutt
15. Birthplace Charlottesville Va.

16 (a) Informant E. M. Terry
(b) Address 1807 W. Lexington St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School DEC 22 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 30 1947 (Date rec'd by registrar) (Signature of local registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1947, at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 1947 to 12-21 1947, and that I last saw h. alive on 12-21 1947.

Immediate cause of death: Asphyxia caused by mucus in Trachea — Duration: few minutes

Due to

Due to

Other Conditions: Prematurity

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Raemin M. D.
Address 206 S. Gilmor St. Date signed 12-24-47

G58536 B.C 2-97710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G58536

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green Sts

(c) Hospital or institution:

University Hospital 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4312 Parkside Drive

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Dudley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1947

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name James Knox Dudley Jr.

13. Birthplace Balto Md

MOTHER

14. Maiden Name Catherine Walker

15. Birthplace Balto Md.

16 (a) Informant Catherine Walker Dudley

(b) Address 9312 Parkside Dr.

17 (a) Burial (b) Date thereof 12/31/47

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md

18 (a) Funeral director Ulmer Funeral Home

(b) Address Balto

19 (a) DEC 30 1947 (b) Huntington for Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1947, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1947, to Dec 29 1947, and that I last saw h.. alive on Dec 29 1947

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Prematurity (28-30 wks)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Jo Shea

Address Univ Hosp. Date signed 12/30/47

VS 150

X

G58537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

Registered No. G58537

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st St. & Wyman Pk. Dr.
(c) Hospital or institution: U. S. Marine Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days) 58 y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4314 La Salle Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Louis (LEWIS) Hollmeyer

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Div.

6 (b) Name of husband or wife [illegible]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 6, 1889

8. AGE: Years	Months	Days	If less than one day
58	8	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation plumber
11. Industry or business

FATHER
12. Name John Hollmeyer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Susan Diller
15 Birthplace Baltimore, Md.

16 (a) Informant Hospital records
(b) Address Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto
18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd
19 DEC 30 1947 Washington Williams M.D. Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1947 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1947 to Dec. 28 1947 and that I last saw him alive on Dec. 28 1947

Immediate cause of death	Duration
Broncho pneumonia, bilateral	3-4d
Due to Carcinoma of tongue	6 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Wide-spread metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature V. J. Dennett
Address Marine Hospital Date signed 12/28/47

X

58538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58538 Registered No. 124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6812- Harford Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6812- Harford Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Anna Preisinger

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-22-8738

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1st, 1926

8. AGE: Years	Months	Days	If less than one day
21	2	9 29	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Stewart & Co.
11. Industry or business Clerk

FATHER
12. Name Jno. Henry Preisinger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Edna Clare Voelker
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Edna C. Preisinger
(b) Address 6812- Harford Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 DEC 30 1947 (b) Livingston Williams Registrar
(Date received by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1947 at 4.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhage, intra-pinfual due to ruptured diffluential varix.
Due to Portal cirrhosis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl A. Royer M.D.
Medical Examiner
Date signed 12-30-47

G58539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G58539

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital 15 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. None given
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Hann

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Not given
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10, 1886

8. AGE: Years	Months	Days	If less than one day
61	1	15	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Steam Engineer
11. Industry or business

FATHER
12. Name William Hann
13. Birthplace Penna

MOTHER
14. Maiden Name Margaret Kauffman
15 Birthplace Penna

16 (a) Informant Robert Chas Hann
(b) Address Mt. Connellsville Pa.

17 (a) Bethlehem (b) Date thereof Jan. 2-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bethlehem
Location Mt Connellsville Pa.

18 (a) Funeral director J. F. Elem. Sons
(b) Address Uniontown Pa
19 DEC 30 1947 Washington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1947, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1947 to Dec 25 1947 and that I last saw him alive on Dec 25 1947

	Duration
Immediate cause of death Uremia	7 da
Due to Chronic Glomerular nephritis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Henry V. Chance M.D.
Address Mercy Hospital Date signed 12/30/47

VS 150

G58540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58540

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) ~~Hospital or institution~~: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Crach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8, 1862

8. AGE: Years	Months	Days	If less than one day
85 86	10	23 21	hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Crachs
13. Birthplace Bohemia

MOTHER
14. Maiden Name Annie Hasenvitz
15. Birthplace Bohemia

16 (a) Informant Estelle Luts
(b) Address 1200 Valley St.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 12-31-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Crouchelar
(b) Address 900 N. Calvert st

19 [illegible] (Registrar) Curtis Jon Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29, 1947, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 29 1947 and that I last saw him alive on Dec 28 1947.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	8 yrs
Due to	
Other Conditions Cerebral Arterio Sclerosis	6 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall MD M. D.
Address 1631 E North av Date signed Dec 30 47

X

G58541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G58541 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A A Co.
(c) City or town West River
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie C. Murray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm P. Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 - 1863

8. AGE: Years 84 | Months 5 | Days 30 | If less than one day hr. min.

9. Birthplace West River Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Fennick Hall
13. Birthplace A A. Co

MOTHER
14. Maiden Name Nancy Chester
15. Birthplace A A Co Md

16 (a) Informant Wm P. Murray
(b) Address West River Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1 48 (month) (day) (year)
(c) Cemetery or crematory West River
Location West River Md

18 (a) Funeral director E. M. Lamoreaux
(b) Address 1003 W. Baltimore St.

DEC 31 1947 (Date rec'd by registrar) (b) Huntington Williams Hall

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1947, at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1947 to Dec 30 1947 and that I last saw h[illegible] alive on Dec 30 1947.

Immediate cause of death: Cardiac decompensation — Duration
Due to: Hypertensive arterio-sclerotic heart disease
Due to:
Other Conditions: Fracture 2 repair femur - intertrochanteric
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~ Accident
(b) Date of occurrence Dec 27 at 9 a M
(c) Where did injury occur? Uniontown Freedom Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Carroll Manor Home While at work? No (Specify home, farm, etc.)
(e) Means of injury: Fell down stairs

23. Signature: [illegible] Jr
Address Union Hosp. Date signed 12/30/47 M.D.

VS 130

Approved 12/30/47 Jay P. Sokolowski MD

C58542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G58542 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4708 Catalpha Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4708 Catalpha Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA JANE ROBINSON

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1862

8. AGE: Years	Months	Days	If less than one day
85	1	5	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Worthington Fringer
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Sarah Wolfe
15. Birthplace: Maryland

16 (a) Informant: Mrs. Charlotte Parsons
(b) Address: 4708 Catalpha Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 DEC 31 1947 (Date received by registrar) (Huntington Williams M.D.)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH December 28 1947, at 1.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26- 1947, to Dec 28 1947, and that I last saw her alive on Dec 27- 1947.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Cardiac Asthma	3 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E Gill Hall M. D.
Address 1631 E North Av Date signed Dec-29-47

X

G58543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G58543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Ostend Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM FORD

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Langston S.C. (Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business American Wiping Cloth Co

FATHER
12. Name ?
13. Birthplace S.C.

MOTHER
14. Maiden Name ?
15. Birthplace S.C.

16 (a) Informant Evelyn McCleen
(b) Address 1133 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1364 N. Central Ave

19 DEC 31 1947 (Date rec'd by registrar) (Registrar) Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1947, at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic aortitis
Myocardial hypertrophy, dilatation and degeneration.
Edema of lungs
Other Conditions Encephalomalacia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/30/47

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 558544 (558544)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2436 St. Paul Street
(c) Hospital or institution: at his home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County Jefferson
(c) City or town Fairfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. — ? —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Lee Locke

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Cora M. Locke
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) March 14 1871

8. AGE: Years	Months	Days	If less than one day
76	9	16	hr. min.

9. Birthplace Libertyville - Iowa
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Metal Smith

FATHER
12. Name John T. Locke
13. Birthplace Indiana

MOTHER
14. Maiden Name Eliza A. McCreery
15. Birthplace Martinsburg - Iowa

16 (a) Informant Cora M. Locke (wife)
(b) Address Fairfield - Iowa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-47 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Fairfield Iowa.

18 (a) Funeral director Stewart & Mowrer
(b) Address 108 W North Ave.

DEC 31 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Dec 1947, at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1947 to 30 Dec 1947, and that I last saw h[im] alive on 26 Dec 1947.

Immediate cause of death: Chr. Cardiac Decompensation — Duration 2 hrs.
Due to Arteriosclerotic Cardio Vascular Renal Disease — 15 years
Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence L. Lemon M.D.
Address 1008 Glendale Ave Date signed 31 Dec 47

VS 150

G58545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

G58545 Registered No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3514 Clifton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Kerr Davie

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife Henrietta Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1866

8. AGE: Years	Months	Days	If less than one day
81	3	3	hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15 Birthplace Unknown

16 (a) Informant Miss M. Catherine Davies - Daughter
(b) Address 3514 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/42 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto, Md

18 (a) Funeral director Wm. J. Tickner & Sons Inc
(b) Address Wash & Pa Aves. Balto, Md

19 DEC 31 1942 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1942, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1940 to 12-29-1942, and that I last saw h/m alive on 12-29-1942

Immediate cause of death	Duration
Coronary Embolism	2 days
Due to	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Howard W. Warner M.D.
Address 1604 Garrison Blvd Date signed 12-30-42

VS 150

58546 Mdlg's for Seingweld

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58546 12/1a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yeds

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 Shadyside Rd (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Russell

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: LAURA M. RUSSELL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-10-69

8. AGE: Years 78 | Months 10 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Instructor J.H.H.
11. Industry or business

FATHER
12. Name Joseph H. Russell
13. Birthplace Pa

MOTHER
14. Maiden Name ? UNKNOWN
15. Birthplace ? "

16 (a) Informant MRS. LAURA M. RUSSELL-WIFE
(b) Address 1607 S HADYSIDE RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/2/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ LORRAINE CEM
Location BALTO., MD

18 (a) Funeral director WM J. TICKNER & SONS INC
(b) Address North & Pa Aves, Balto, MD

19 (a) DEC 31 1947 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30 1947 at 1 05 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26 1947 to 12-30 1947 and that I last saw him alive on Dec 30 1947

	Duration
Immediate cause of death: Uremia	
Due to: Hypertensive Cardio-vas. disease; Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 12-30-47

X

G58547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G58547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1378 Pentwood Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-9
(e) Length of stay in Baltimore (yrs., mos., or days) 83 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1378 Pentwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FREDERICK E. ANDREAE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Married

6 (b) Name of husband or wife: Johanna M. Andreae
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1865

8. AGE: Years	Months	Days	If less than one day
82	5	7	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Sign Painter
11. Industry or business Self

FATHER
12. Name ? Andreae
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. A. Keene
(b) Address 1378 Pentwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/47 (month) (day) (year)
(c) Cemetery or Crematory Western
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) DEC 31 1947 (Date rec'd by registrar) (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1947, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1947 to Dec. 29 1947 and that I last saw him alive on Dec. 26 1947

Immediate cause of death: Hypertensive C.V. Dis. — Duration:
Due to:
Due to:
Other Conditions Cong. Heart Failure
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin Ellerson M. D.
Address 4037 Eddy Rd. Date signed 12/30/47

658548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

658548 Registered No. 1170

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 314 North Mount Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-
(e) Length of stay in Baltimore 49 (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 314 North Mount Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ollie Louden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 1, 1885

8. AGE: Years 62 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Essex County Va (Town, county, and state)

10. Usual Occupation Self Employed

11. Industry or business

FATHER 12. Name Haver Louden

13. Birthplace Essex county Va.

MOTHER 14. Maiden Name Citella Louden

15. Birthplace Essex County Va

16 (a) Informant Mrs Louden

(b) Address 314 North Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 31 1947 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimore city.

18 (a) Funeral director Joseph A. Straley

(b) Address 66 West Baltimore street

DEC 31 1947 (Date rec'd by Registrar) (b) Hunting Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1947, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1947 to Dec 28 1947, and that I last saw h[illegible] alive on Dec 28 1947.

Immediate cause of death: Ruptured Gastric Ulcer — Duration: 3 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph W. Redden

Address 426 N. Calvert Date signed 12/30/47

VS 188

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658549

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 E. Fort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1105 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Herzberger (2)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-9362

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Eva F. Herzberger (nee Ray)
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	13	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation At Home (Physically Retired)
11. Industry or business —

FATHER
12. Name George Herzberger
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Fate (nee?)
15. Birthplace Balto Md.

16 (a) Informant Mrs. Eva F. Herzberger (Wife)
(b) Address 1105 E. Fort Ave. Balto 39 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Anne Arundel Co. Md.

18 (a) Funeral director C. Howard Evans
(b) Address 4005 S. Charles St.

19 DEC 31 1947 Registered by Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Tues., Dec. 30 1947, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947 to Dec 30 1947 and that I last saw him alive on Dec 30 1947

Immediate cause of death	Duration
Exhaustion	24 hrs.
Due to Cerebral Hemorrhage	3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. Campbell M. D.
Address 1647 Bennett St. Date signed 12/30/47

G58550 LV 105869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/12

G58550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ola Belle Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife William Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6- 1915

8. AGE: Years	Months	Days	If less than one day
32	-	23	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Daniel Addison
13. Birthplace S.C.

MOTHER 14. Maiden Name Frances Ward Addison
15. Birthplace S.C.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/47 (month) (day) (year)
(c) Cemetery or crematory Candy Hill
Location Camden S.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address Elroy O. Wilson 1000 Druid Hill Ave.

DEC 31 1947 (Date rec'd by registrar) Washington Williams

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29-47 19 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6- 1946 to 12-29- 1947 and that I last saw her alive on 12-29 1947

Immediate cause of death	Duration
Tuberculosis of Lungs, Laryngeal & Intestines	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dwight W. Parks M. D.
Address Balt. City Hosp. Date signed 12-30-47

X

S.S.# 214-26-4172.

G58551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58551 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Weems Creek (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Stanely Cooley

3 (b) If veteran, name war

3 (c) Social Security Account No. Single 214-26-4172

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 - 29

8. AGE: Years	Months	Days	If less than one day
18	5	24	hr. min.

9. Birthplace Wash D.C (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name Ezra J. Cooley

13. Birthplace Montana Missouri

MOTHER 14. Maiden Name Marie A Joachim

15. Birthplace East Port Md

16 (a) Informant Ezra J. Cooley

(b) Address Annapolis

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2-48 (month) (day) (year)

(c) Cemetery or crematory Annapolis

Location Annapolis Md

18 (a) Funeral director E W Lamarcegen

(b) Address 103 W Balto St

19 DEC 31 1947 (Date rec'd by registrar) (Signature for Williams M.D. Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1947, at 6.30P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Ruptured Kidney
Fract 1-9 Ribs, Rt

Due to

Other Conditions Ruptured Liver
Ruptured Spleen

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-30-47 at 6 P. M.

(b) Where did injury occur? Ritchie Highway & Porter Drive- Anne Arundel Co.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Passenger in auto- truck side swaped

23. Signature Earl L Royle M.D. (Medical Examiner)

Date signed 12-31-47

658552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

658552 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 N. Pine St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Pine St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LOLA WILSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Robert
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 1/22/1910

8. AGE: Years	Months	Days	If less than one day
37	11	6	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Jones
15 Birthplace Va

16 (a) Informant Robert Wilson (Hus.)
(b) Address 16 N. Pine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

DEC 31 1947 (Date rec'd by registrar) (b) Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28th 1947, at 10:20 P

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1947 to 12/28 1947, and that I last saw h[illegible] alive on 12/27 1947

Immediate cause of death	Duration
(a) Lobar Pneumonia acute	2 wks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address 1111 N. Lee Date signed 12/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARROW RESERVED FOR BINDING

58553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G5855896 58553

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 Dimon St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) over 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Dimon St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Forrester Keys

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Herman Keys
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Jan 10 1894

8. AGE: Years 53 | Months 11 | Days 19 | If less than one day ___ hr. ___ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation House Wife
11. Industry or business own home

FATHER 12. Name Richard Forrester
13. Birthplace md

MOTHER 14. Maiden Name Clara Forrester
15. Birthplace Md

16 (a) Informant Herman Keys
(b) Address 2022 Dimon St.

17 (a) Burial (b) Date thereof 12/31/47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Geo. M. Kelso
(b) Address 1303 Pennsylvania Ave

19 (a) DEC 31 1947 (b) Washington D.C.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29-1947, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18-1946 to 12-29-1947 and that I last saw h[illegible] alive on 12-29-1947.

Immediate cause of death Carcinoma Uteri — Duration: 1 year

Due to — Duration: over a year

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N Stricker Date signed 12-31-47

VS 150

X

G58554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G58554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 N. Eutaw St. 17
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 62 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 N. Eutaw st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Eva Clark (Alleged Alias: Eva Frances)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1893

8. AGE: Years	Months	Days	If less than one day
54	5	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Edward Clarke
13. Birthplace Baltimore

MOTHER
14. Maiden Name Matilda Macksback
15. Birthplace Ireland

16 (a) Informant Mr. Maurice J. Clark
(b) Address 624 N. Eutaw

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2-47 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location New Cathedral Cemetery

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

DEC 27 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 December 1947 at 9:15 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Oct. 1947, to 29 Dec. 1947, and that I last saw her alive on 29 Dec. 1947.

Immediate cause of death	Duration
Carcinomatosis	
Due to Adenocarcinoma Colon	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: 7 Nov. 47 Adenocarcinoma

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joh O'Rourke M.D.
Address West Balt. Gen. Hosp. Date signed 29 Dec 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

G58555

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Comb Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male.

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Thomas Fulmon
(b) Address 610 Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co Md

18 (a) Funeral director Isaiah L Bennett
(b) Address 108 N Montgomery St

19 (a) 1947 (b) Date rec'd by Washington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1947, at 8.45 a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis
Due to Myocardial hypertrophy, dilatation, and degeneration
Other Conditions Rt. inguinal hernia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner
Date signed 12/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58556 — BALTIMORE CITY HEALTH DEPARTMENT — G58556

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Leary St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 William St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Farran

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife James E. Farran

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1863

8. AGE: Years 84 | Months — | Days — | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name — Haynie
13. Birthplace Virginia

MOTHER
14. Maiden Name Not known
15. Birthplace "

16 (a) Informant Mrs. Madeline Headley
(b) Address 1007 Riverside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 1-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director Elizabeth Hartz Inc.
(b) Address 115 E. West St.

19 (a) (Date received) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1947, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1947 to Dec 28 1947 and that I last saw h-lr alive on Dec 28 1947.

	Duration
Immediate cause of death: Acute Cardiac Dilitation	Min. Hr. Da. Mo. Yr.
Due to: Cardio-Vascular disease	2
Due to:	
Other Conditions: Hemiplegia	3 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Forrest St. Date signed Dec 31

G58557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G58557 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT STR RUTLAND AVE.
(c) Hospital or institution:
SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2WKS
(e) Length of stay in Baltimore (yrs., mos., or days) 6WKS.

2. USUAL RESIDENCE OF DECEASED:
(a) State PENNSYLVANIA (b) County SOMERSET
(c) City or town SOMERSET
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. # 4
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ETHEL STOKER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife GEORGE STOKER
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) DECEMBER 5 1876

8. AGE: Years	Months	Days	If less than one day
61	0	26	____ hr. ____ min.

9. Birthplace HYNDMAN, BEDFORD CO. PA.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business OWN HOME

FATHER
12. Name MARSHALL LEASURE
13. Birthplace BEDFORD CO. PA.

MOTHER
14. Maiden Name — BITTNER
15 Birthplace BEDFORD CO. PA.

16 (a) Informant James A. Rahauser
(b) Address 2311 Oswego AV

17 (a) Burial (b) Date thereof JANUARY 3 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SOMERSET CO MEM. PARK
Location SOMERSET, PA.

18 (a) Funeral director Stevanus Lee Manner Co.
(b) Address 108 W. North Ave. City #1.

19 DEC 31 1947 (b) Huntington Williamsport Md
(Received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 31, 1947 at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from DEC. 10, 1947 to DEC 31, 1947. and that I last saw her alive on DEC 31, 1947

Immediate cause of death	Duration
Pos pulmonary embolism.	
Due to Pos coronary thrombosis	
Due to Pos heart failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irvin M. Kushner M. D.
Address Sinai Hospital Date signed 12-31-47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write-the causes of death clearly and legibly.

G58558 — BALTIMORE CITY HEALTH DEPARTMENT — G58558 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore - Woodsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Pine Fayette Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary E. Lombard - " Lombard."

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Christopher T.
6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) May 4: 1875

8. AGE: Years	Months	Days	If less than one day
72	7	15	hr. min.

9. Birthplace New York City - N.Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Cornelius Shaughnessy
13. Birthplace New York

MOTHER
14. Maiden Name Mary E. Spencer
15. Birthplace New York.

16 (a) Interment George E. Lombard Sr.
(b) Address 1103 Pine Fayette Ave Balto
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-Jan. 48 (month) (day) (year)
(c) Cemetery or crematory Reed Cathedral
Location Baltimore - Md.
18 (a) Funeral director F. B. Wikert & Son
(b) Address 1900 Eutaw Pl. 17
19 (a) 1 1947 Thurlington Williams M.D.
(Date rec'd by registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30 1947 at 1 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1947 to 12-30 1947 and that I last saw h. alive on 12-30 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Aortic-Vase Accident	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Porter M.D.
Address Bon Secours Hosp Date signed 12-30

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G58559 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Fayette &
(b) Street address 1745 Wilkens Bayard Sts
(c) Hospital or institution:
Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 145 Willard St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Freda Blum Hedwig-Freeda Blum.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Wm. Blum
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) May 7 - 1894

8. AGE: Years	Months	Days	If less than one day
53	7	20	..... hr. ..... min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Herman Kluge
13. Birthplace Germany

MOTHER
14. Maiden Name Frances Chesterfield
15. Birthplace Germany

16 (a) Informant Chas. William Blum
(b) Address 145 Willard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 Dec 27 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director F. B. Gilbert & Son
(b) Address 1300 Eutaw Place

19 Dec 1927 Huntington Williams
(Date rec'd by registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1927, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1927, to Dec 27 1927, and that I last saw h.r. alive on Dec 27 1927.

Immediate cause of death	Duration
Respiratory Failure	
Due to Possible Pneumonia	
Due to Cause of Death	
Other Conditions Hemorrhoids	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec 20 at 5 P.M.
(c) Where did injury occur? Balto Balto Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell down stairs

23. Signature H. K. Carr M. D.
Address Bon Secours Hosp. Date signed 12-27-27
Howard J. Walden, M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

~~W~~ 658560 — 658560 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3050 Stafford St.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3050 Stafford St.
(If rural give section)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Thomas B. Anderson.

3 (b) If veteran, name war
3 (c) Social Security Account No. 213-10-0660

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha M. Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 1894

8. AGE: Years	Months	Days	If less than one day
53	4	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired Mathematician
11. Industry or business Previously Transit Co

FATHER
12. Name Wm J. Anderson
13. Birthplace Md

MOTHER
14. Maiden Name Regina Groh
15. Birthplace Md

16 (a) Informant Rudolph W. Anderson
(b) Address 3050 Stafford St

17 (a) Burial (b) Date thereof 27 Dec. 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Calvary Cemetery
Location Baltimore - Md

18 (a) Funeral director F. B. Wilkens & Son
(b) Address 1300 Eutaw Pl 17

19 (a) 1947 (b) Clinton Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/47 19 at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1/47 19 to 12/27 19, and that I last saw h alive on 12/22/ 1947.

Immediate cause of death Coronary Occlusion — Duration 1 Mth
Due to
Due to
Other Conditions Arterio Sclerosis ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature D. P. Magee M.D.
Address 336 N Paca St Date signed 12/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

658561 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1935 W. Lafayette St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Charles Jerome O'Brien

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ada M.

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug. 9. 1889

8. AGE: Years	Months	Days	If less than one day
58	3 4	19	— hr. — min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation Supt. Brooklyn Corp.

11. Industry or business R.R. Carmen

FATHER
12. Name John O'Brien
13. Birthplace Ireland

MOTHER
14. Maiden Name Sweeney
15. Birthplace Ireland

16 (a) Informant C. Edward O'Brien
(b) Address 1935 W. Fayette St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 31- Dec 47 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director H. B. Stephan & Son
(b) Address 1700 Eutaw Place

19 (a) Date received by registrar (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 - 1947 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Month 1947 to Dec 28 1947 and that I last saw h[illegible] alive on Dec 28 1947

Immediate cause of death Apoplexy — Duration

Due to Hypertension and arteriosclerosis

Due to Generalized

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address 3033 W North Ave Date signed 12/29/47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658562
GM. 116071

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

658562 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 N. Charles ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Lloyd - Or - Carry Lloyd

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10 - 1917

8. AGE: Years	Months	Days	If less than one day
30	11	21	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Emory Lloyd
13. Birthplace Penna.

MOTHER
14. Maiden Name Clara Wise
15. Birthplace Penna.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof Dec 31 47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Lukes York Co Pa
Location Pennsylvania

18 (a) Funeral director Diemans Body Dre
(b) Address 1217 St Paul St.

19 (a) (b) (Signature of registrar)

DEC 31 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 - 1947, at 5.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23-1947 to Dec. 31 - 1947, and that I last saw her alive on Dec. 31 - 1947

Immediate cause of death	Duration
Tuberculosis of Lungs, Ulceration	5yrs
Due to	
Due to	
Other Conditions Tuberculous Pharangitis (Include pregnancy within 3 months of death)	6 mo

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Luigi F. W. Paulos M. D.
Address Bal City Hosp Date signed 12-31-47

G58563 BALTIMORE CITY HEALTH DEPARTMENT G58563
CERTIFICATE OF DEATH 937 (Registered No.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15"
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1704 No Appleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ellis Whitehead
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Anna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1872
8. AGE: Years 75 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Rosalie
15. Birthplace Russia

16 (a) Informant Anna Whitehead
(b) Address 1704 No Appleton St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-1-48 (month) (day) (year)
(c) Cemetery or crematory Adas Israel
Location No Point of Germano Hall Rd
18 (a) Funeral director Jack Levin Inc
(b) Address 1400 Eutaw Place
19 Dec 31 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1947, at 5:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1947 to Dec. 31 1947, and that I last saw him alive on Dec. 31 1947

	Duration
Immediate cause of death: Cerebro-vascular accident	3 days
Due to: Hypertensive cardio-vascular disease	4 years
Due to:	
Other Conditions: Pernicious Anemia	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. Goldstein M. D.
Address WBJA Date signed 1-2-31

X

G58564 ✓ G58564

G58564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 100 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calvert Sts
(c) Hospital or institution: Franklin Sq. Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 E. Clement St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ~~Frank Scheeler~~ Franklin W. Scheeler

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-8660

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife (nee Wroten) Gertrude V. Scheeler

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) January 19, 1890

8. AGE: Years 57 | Months 11 | Days 11/12 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Floorman for Balto

11. Industry or business Copper Paint Co.

FATHER
12. Name Jolyn Scheeler
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Elizabeth Grill
15. Birthplace Balto Md

16 (a) Informant Mrs. Gertrude V. Scheeler (Wife)
(b) Address 524 E. Clement Balto 39 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location a a Co Md

18 (a) Funeral director A. J. Bowman & Evans
(b) Address 1400 S. Charles St. (20)

19 (a) DEC 31 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31/1947, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Dec 1947, to 31 Dec 1947, and that I last saw him alive on 31 Dec 1947.

Immediate cause of death	Duration
Pulmonary embolism	
Due to Thrombophlebitis	
L. st. leg.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq. Hosp. Date signed 31 Dec 47

X

E-585641/2 ✓ E-585641/2

BC-675985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County .....
(c) City or town BALTIMORE 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3613 WINDSOR MILL RD, City 16
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME BABY BOY HUNGERFORD

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 APRIL 1947

8. AGE: Years | Months | Days | If less than one day: 8 hr. 33 min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name WILLIAM T. HUNGERFORD
13. Birthplace SMITHBURG, PENNA

MOTHER
14. Maiden Name BETTY ELIZABETH HORN
15 Birthplace MARYLAND

16 (a) Informant FATHER
(b) Address 3613 WINDSOR MILL RD, CITY

17 (a) CREMATION (b) Date thereof APRIL 12 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory UNION MEMORIAL HOSP
Location 33RD & CALVERT STS.

18 (a) Funeral director .....
(b) Address .....

19 MAY 19 1948 (Huntington Williams M.D.)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 11 1947, at 11:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 APRIL 1947 to 11 APRIL 1947, and that I last saw h/m alive on 11 APRIL 1947.

Immediate cause of death	Duration
INTRACRANIAL HEMORRHAGE	
Due to	
Due to	
Other Conditions UMBILICAL CORD ARTERY NECK	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: INTRACRAN. HEM; ATELECTASIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Malcolm J. Scott M. D.
Address Union Memorial Hosp Date signed 4/12/47

DUPLICATE X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G58565

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 So Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Joseph Mazzcko (MLYCZKO)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace Poland

MOTHER 14. Maiden Name Agnes

15. Birthplace Poland

16 (a) Informant St. Agnes Hospital

(b) Address Caton ave.

17 (a) Burial (b) Date thereof 1/1/48 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loyal Heart Cemetery

Location Keyser Mill Rd

18 (a) Funeral director John J. Fahey & Sons

(b) Address 43 W. Lafayette St

19 (a) 1/1/48 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31st 1947 at 8:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Dec 1947 to 30 Dec 1947 and that I last saw h[illegible] alive on 29 Dec 1947

Immediate cause of death	Duration
Myocardial Infarction	
Due to Coronary artery Occlusion	
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Hamill M.D.

Address St. Agnes Hosp. Date signed 31 Dec 47

X

G58566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

G58566 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Middleburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wade Shurman (SHERMAN)
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-05-9844

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Nettie B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29 1901

8. AGE: Years 46 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Charles Sherman
13. Birthplace Md

MOTHER 14. Maiden Name Daisy Coleman
15. Birthplace Md.

16 (a) Informant Mrs. Daisy B. Sherman
(b) Address Middleburg Md.

17 (a) Burial (b) Date thereof 1-3-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Middleburg
Location Carroll Co. Md

18 (a) Funeral director C. O. Zurn & Son
(b) Address Taneytown Md.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 1 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 1947 to 12/31 1947, and that I last saw h. l. alive on 12/31 1947.

Immediate cause of death	Duration
Cerebral anemia	
Due to Gastric anemia	
Due to Hodgkin's Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Elliott
Address Univ. Hosp. Date signed M. 1 D. 1/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 658567 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1023 Warden St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Warden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Kinnmitt

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Kinnmitt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1877

8. AGE: Years: 70 | Months: 7 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual Occupation: House work
11. Industry or business: at Home

FATHER
12. Name: Patrick Farrell
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Katherine O'Neill
15. Birthplace: Ireland

16 (a) Informant: Mrs. Mary E. Eagers
(b) Address: 1023 Warden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cemetery
Location: 4309 Old Frederick Rd

18 (a) Funeral director: Edmund W. Coughlin & Son
(b) Address: 924 E. Eagers St.

19 (a) [illegible] (Date received by registrar) (b) Huntington Williams [illegible]

JAN

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1947, at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 May 1947 to 30 Dec 1947, and that I last saw h[illegible] alive on 30 Dec 1947

Immediate cause of death: Cerebral hemorrhage — Duration: 1 week.
Due to: Essential hypertension — Duration: 7
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Samuel Silverfield, M.D.
Address: 714 E. Preston St. Date signed: 1 Jan 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

658568 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Trenton (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Perry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John S. (Stacy) Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20, 1891

8. AGE: Years (56) | Months | Days | If less than one day hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas H. Kelly
13. Birthplace Trenton New York

MOTHER 14. Maiden Name Mary (Stacy)
15. Birthplace Ontario Canada

16 (a) Informant
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-3-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Richmond Va.

18 (a) Funeral director Allen C. Malley Inc
(b) Address 2435 E Ollney St

19 (a) (Date filed by registrar) (b) Huntington Hill

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1947, at 1 60 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertrophy & Acute Dilatation of Heart

Due to

Other Conditions Acute Fatty Degeneration of Liver.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallis M.D.
Medical Examiner.
Date signed 12-31-47

95c

G58569 BALTIMORE CITY HEALTH DEPARTMENT G58569
CERTIFICATE OF DEATH 131A Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution Provident 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Virginia Mitchell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Fe | 5. Color or race N | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace Henderson, N. C. (Town, county, and state)

10. Usual Occupation Domestic.

11. Industry or business

FATHER 12. Name Rev. William Mitchell
13. Birthplace Franklin N.C.

MOTHER 14. Maiden Name Cora Stone
15. Birthplace Kittrell N.C.

16 (a) Informant Max Mitchell
(b) Address 932 Saratoga St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/1/48 (month) (day) (year)
(c) Cemetery or crematory Franklin
Location N.C.

18 (a) Funeral director Joseph C. Burns
(b) Address 129 McCulloh St Washington Williams, Mgr.

(a) JAN 2 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 1947, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1947, to 12/29 1947, and that I last saw h[illegible] alive on 12/29 1947.

Immediate cause of death Uremia — Duration 2 days
Due to Hypertensive C.V. Renal Disease — 2 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M. D.
Address 1514 Division Date signed 1/2/1948

JAN 2 - 1948

058570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

058570 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital 12th
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 35
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. The Greenway Apts. (If rural give location)
(e) Citizen of foreign country? No (~~Yes~~ No)
If yes, name country

3 (a) FULL NAME Mrs. Francis P. Murphy (Sallie)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife F. P. Murphy
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 13, 1867

8. AGE: Years	Months	Days	If less than one day
80	6	12	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Philip John
FATHER 13. Birthplace Pennsylvania
MOTHER 14. Maiden Name Jane Wright
MOTHER 15. Birthplace Maryland

16 (a) Informant Austin P. Murphy
(b) Address 321 Tuscany Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN. 2 - 1948 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 11 E. N. Mt. Royal Ave

19 (a) JAN 2 - 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1947 at 8:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1947, to Dec. 30 1947, and that I last saw ~~him~~ her alive on Dec. 30 1947.

Immediate cause of death	Duration
Intestinal obstruction	
Due to Carcinoma of Sigmoid Colon	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Union Mem. Hosp. Date signed 1/2/30

VS 150

058571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1930

Registered No. 058571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

PAGES RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E Calvert St.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County CECIL
(c) City or town Colora
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Brummel Russell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (d) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1864

8. AGE: Years 83 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Edward Thomas Russell
13. Birthplace Maryland

MOTHER
14. Maiden Name Mirian Clendenin
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4 1948 (month) (day) (year)
(c) Cemetery or crematory West Gatlinsburg
Location Colora Md.

18 (a) Funeral director J. E. Tyson
(b) Address Rising Sun Md.

19 JAN 2 - 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1948 at 10:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1947 to Jan. 1 1948 and that I last saw him alive on Jan. 1 1948

Immediate cause of death Toxemia following gangrene of Rt. leg with embolism — Duration

Due to Arteriosclerotic Heart + Auricular fibrillation

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Reuben P. Jones M. D.
Address Union Memorial Hosp. Date signed 1-7-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 058572

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2213- Huntington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK WM. MOHR

3 (b) If veteran, name war	3 (c) Social Security Account No	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
W. W. #1	212-07-6171	Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 1st 1894

8. AGE: Years	Months	Days	If less than one day
53	4	30	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Stock Clerk
11. Industry or business Gas & Electric Co

FATHER
12. Name Charles Mohr
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Dietz
15. Birthplace Germany

16 (a) Informant P. D. Brennan
(b) Address Odenton Md.

17 (a) Cremation (b) Date thereof 1/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery or~~ crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 E. Pay[illegible] St. Huntington Waterloo, Md.

19 (a) JAN 2- 1948 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1947, at 9.30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-31-47

G58573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G58573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 N. Calhoun St
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Victor (Sara) Saro

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Margaret E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-18-[illegible]

8. AGE: Years	Months	Days	If less than one day
64	11	13	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business Southern Hotel

FATHER
12. Name Louis Saro
13. Birthplace Alsace Lorraine

MOTHER
14. Maiden Name Mary M. Bernhardt
15. Birthplace Balto - Md.

16 (a) Informant Margaret Saro
(b) Address 6 N Calhoun St

17 (a) 1-6-48 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore - Md.

18 (a) Funeral director Wilkens Coskery Inc
(b) Address 1717 St. Paul St

19 (a) JAN 2 - 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Jan 1948, at 10:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Dec 1947 to 1 Jan 1948, and that I last saw him alive on 1 Jan 1948

Immediate cause of death	Duration
Cardiac decompensation	
Due to Rheumatic heart disease, active &	
Due to inactive	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq Hosp Date signed 1 Jan '48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44B

Registered No. 658574

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
13
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 Falls Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Dempwolf

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-7-1892

8. AGE: Years 53 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Dempwolf
13. Birthplace Germany

MOTHER
14. Maiden Name A. Smith
15. Birthplace Pa.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (b) Date thereof JAN. 2 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location York Pa.

18 (a) Funeral director Wm Cook, Inc
(b) Address 217 St Paul St

19 (c) JAN 2 - 1948 Washington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1948, at 8:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1947 to Jan 1 1948, and that I last saw h[illegible] alive on Jan 1 1948

Immediate cause of death: Asphyxiation failure
Due to: Bronchial Pneumonia Probable
Due to: Arteriosclerosis disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 1-1-48

PRESS WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. 658575

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 332- N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1882

8. AGE: Years 65 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Charles Bowman

13. Birthplace St. Mary's Co. Md.

MOTHER 14. Maiden Name Tyler

15. Birthplace Maryland

16 (a) Informant Carter B. Jones

(b) Address 332 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2 1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. H. Hoffman

(b) Address 1631 Druid Hill Ave.

19 JAN 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1947, at 8.30a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-29-47

VS 191

G58576 BC-G98125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G58576

IN. 116080

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Webb St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Waters (Evelyn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23rd 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leroy Waters
13. Birthplace Chester, Pa.

MOTHER
14. Maiden Name Pearl ?
15. Birthplace Baltimore, Maryland

16 (a) Informant
(b) Address

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 12-29-47. (month) (day) (year) 900 AM
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 JAN 2- 1948 (Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24th 1947 19 at 1.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23/ 1947 to Dec 24 1947 and that I last saw h er alive on Dec. 24 1947

Immediate cause of death	Duration
Due to Prematurity	1 day
Due to	
Other Conditions Anoxemia	1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian P. Goffin M. D.
Address Balt City Hosps Date signed Dec 28 47

V S 150

G58577 — BALTIMORE CITY HEALTH DEPARTMENT — G58577 Registered No.

CERTIFICATE OF DEATH 1930

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 W. LAFAYETTE
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) ABOVE ADDRESS 20 YRS
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 W. LAFAYETTE AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA FUSCO

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife SAMUEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 11, 1869

8. AGE: Years	Months	Days	If less than one day
78	—	9 19	hr. min.

9. Birthplace ITALY (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name LEONARD DE NOVA
13. Birthplace ITALY

MOTHER
14. Maiden Name UNKNOWN
15 Birthplace ..

16 (a) Informant MR. ANTONIA GRAZIANO
(b) Address 25 15 W LAFAYETTE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/2/48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BALTIMORE, MD

18 (a) Funeral director WM J. TICKNER & SONS INC
(b) Address North & Pa Aves BALto, MD

19 (a) JAN 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1947, at 2.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to Dec 29 1947 and that I last saw her alive on Dec 29 1947

Immediate cause of death	Duration
Arteriosclerotic Cardio Vascular Disease	
Due to Bronchopneumonia	
Due to	
Other Conditions Varicose Ulcers of Leg	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Mustich M.D.
Address 2302 Edmondson Ave Date signed 12/31/47

G58578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G58578 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4-2
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Louis Burrier BURRIER

3 (b) If veteran, name war: None

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sophia K. Burrier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years: About 65 | Months | Days | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business

FATHER
12. Name: John Burrier
13. Birthplace: Md.

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace

16 (a) Informant: Mrs. Catherine Cluster
(b) Address: 5709 Jonquil Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/48 (month) (day) (year)
(c) Cemetery Holy Redeemer
Location: Balto. Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: North & Pa. Aves., Balto. 17, Md.

19 (a) JAN 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1947 at 1 15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 12-30-47

158579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 158579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3805 Belair Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3805 Belair Road. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George W Reinhardt

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine M Reinhardt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1875

8. AGE: Years	Months	Days	If less than one day
72	5	24	hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation Coal Salesman

11. Industry or business

FATHER 12. Name Philip Reinhardt

FATHER 13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Elizabeth Umbach

MOTHER 15. Birthplace Germany

16 (a) Informant Mrs. Katherine M Reinhardt

(b) Address 3805 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3, 1948 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Taylor Ave Balto Md

18 (a) Funeral director Albert L Hilt Jr

(b) Address 1606 N Chester St

19 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1948, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Jan 1 1948; and that I last saw h[illegible] alive on 12/31 1947.

Immediate cause of death	Duration
Cardiac Failure.	5 days
Due to Cerebral Hemorrhage.	5 weeks.
Due to Arteriosclerosis.	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J S Hardesty M. D.

Address 3805 Belair Rd Date signed 1/1/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write th

458580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. 458580

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 S.W. 8th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isadora Farbman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE: Years: 57 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Laundry

11. Industry or business

FATHER
12. Name: Saul Farbman
13. Birthplace: Russia

MOTHER
14. Maiden Name: unknown
15. Birthplace: Russia

16 (a) Informant: JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-48 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Mt Carmel
Location

18 (a) Funeral director: Jack Levey Inc
(b) Address: 2100 Eutaw Place

19 (a) JAN 2 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 1 1948, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1947, to Jan. 1 1948, and that I last saw him alive on Jan. 1 1948.

Immediate cause of death	Duration
Brain tumor probably a malignant glioma of	
Due to left cerebral hemisphere	2 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: increased intracranial pressure
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: George G. Cuthbert
Address: Johns Hopkins Hosp. Date signed 1-1-48 M. D.

VS 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658581

658581 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hosp. D
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 WILKENS Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda E. Campbell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife Patrick Campbell
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Feb. 13 1868

8. AGE: Years	Months	Days	If less than one day
79	10	19	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Hood
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore Md

16 (a) Informant William F. Hake
(b) Address 2701 Wilkens Ave.

17 (a) Buried (b) Date thereof 1 Jan 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director P. D. Herbert & Son
(b) Address 1300 Eastern Ave

19 (a) JAN 2 - 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1947, at 5:02 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1947 to 12/30 1947, and that I last saw her alive on 12/30 1947.

Immediate cause of death	Duration
RESPIRATORY FAILURE	4 HRS.
Due to BRONCHIAL PNEUMONIA	6 days
Due to	
Other Conditions INANITION DEHYDRATION	6 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Huntington Williams M.D.
Address 33½ E. Frederick Ave Date signed 1/31/47
Catonsville Md.

VS 150

58382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 58382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave -
(c) Hospital or institution:
St. Agnes Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Winchester Street
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Girl Goldsmith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-30-47

8. AGE: Years | Months | Days: 1 | If less than one day: 24 hr. min.

9. Birthplace St. Agnes Hospital
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Charles Gilbert Goldsmith
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ruth Mildred MacKenzie
15. Birthplace Baltimore Maryland.

16 (a) Informant Charles G. Goldsmith
(b) Address 2803 Winchester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Harry H Wiltse
(b) Address 4104 Liberty Ave

19 (a) JAN 2 - 1948 (Date rec'd by registrar) (b) Catonsville, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1947, at 8 65 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Hugh A. Ellis Wells M.D.
Address St. Agnes Hosp. Date signed 12/31/47

VS 150

G58583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G58583 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 753 W. Fayette St.
(c) Hospital or institution: 4-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 753 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Craig
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-03-1378

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1882.

8. AGE: Years 65 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business Foster Bros.

FATHER 12. Name Robt. Moore Craig
13. Birthplace Unknown

MOTHER 14. Maiden Name Lallie Priscilla
15. Birthplace Unknown

16 (a) Informant Robt. Allman
(b) Address 753 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3/48 (month) (day) (year)
(c) Cemetery or crematory Ludow Pk.
Location 3501 Erdman Ave.

18 (a) Funeral director Harry H. Wittstadt
(b) Address 4101 Edmondson Ave

19. JAN 2 - 1948 (Date received by registrar) (c) Registrar for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to Dec 31 1947 and that I last saw h[illegible] alive on Dec 31 1947.

Immediate cause of death: Acute Cardiac Dilatation — Duration 1 day

Due to: Hypertensive Cardio-vascular disease — 7

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Fayette St Date signed Jan 2 '48

058584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 1 058584

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6732 Boston Ave
(c) Hospital or institution: Home 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 6732 Boston Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Jacob Kaufman

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-22-4616

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband~~ wife: Agnes C.
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Jan. 10 - 1887

8. AGE: Years 60 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Corp.

FATHER
12. Name Jacob Kaufman
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Barbara Graf
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Agnes C. Kaufman
(b) Address 6732 Boston Ave. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-1948 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md

18 (a) Funeral director George A. Weber
(b) Address 705 S. Ann Street

19 (a) Filed Jan 2, 1948 (b) Signature of Registrar [illegible]

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1st 1948 at 1:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947, to Jan 1 1948, and that I last saw him alive on Jan 1 1948

Immediate cause of death: Coronary Thrombosis — Duration 6 Mo

Due to: Arteriosclerotic C.V. Disease

Due to:

Other Conditions: Benign Pulmonary mass - Left Lung.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen C. Mochonick, M.D.
Address 6714 Holabird Ave Date signed 1/5/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

658585 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 South Wolfe Street
(c) Hospital or institution: Home 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 South Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Heliński

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of [redacted] wife Rosalie
6 (c) If alive, give age deceased

7. Birth date of deceased (mo., day, yr.) July 15, 1880

8. AGE: Years	Months	Days	If less than one day
67	5	16	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Peter Helinski
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria ?
15. Birthplace Poland

16 (a) Informant Mrs Anna Barlow (Daughter
(b) Address 910 South Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-48 (month) (day) (year)
(c) Cemetery or [redacted] St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) Filed 2 1948 (b) Registrar [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1948, at 12 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1947 to Jan 1 1948, and that I last saw h[illegible] alive on Dec 31 1947.

Immediate cause of death	Duration
Generalized senile changes	
infirmity arteriosclerosis	
Duodenal ulceration	1 mo 7
Pernicious infection of face	3 yrs. +
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lee A. Lefevre M. D.
Address 1[illegible] Date signed 1/12/48

V S 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 182a

Registered No. 58536

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Fullerton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ingleside Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Lee Lowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-27-47

8. AGE: Years | Months | Days 5 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Walter L. Lowman
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Catherine M. Brown
15. Birthplace Baltimore, Md.

16 (a) Informant Catherine M. Lowman
(b) Address Fullerton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 Jan 48 (month, day) (year)

(c) Cemetery or crematory Friends Lot
Location Back County Yard

18 (a) Funeral director F. P. Wiggerton Son
(b) Address 1300 Eastern Ave

19 (a) [illegible] (b) Washington Nativity Co. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31- 1947, at 10 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1947 to 12-31-1947 and that I last saw him alive on 12-31-1947.

Immediate cause of death: Circulatory Failure — Duration

Due to Anoxemia

Due to Respiratory Failure Acute Suffocation & Anoxemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not Granted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accidental
(b) Date of occurrence 12-30-47 at 6 15 M
(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No
(Specify type of place)
(e) Means of injury Fell from bed in hospital

23. Signature Anthony J. D'Paula M. D.
Address St. Joseph's Hospital Date signed 12-31-47
Howard J. Andrews, MD

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0585~~87~~.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 058587

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Cardenas Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Himmelheber (HIMMELHEBER)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife CHAS. HIMMELHEBER
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 71 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace ANNAPOLIS, MD. (Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER
12. Name THOMAS GAITHER
13. Birthplace —

MOTHER
14. Maiden Name REBECCA T. PERRY
15. Birthplace —

16 (a) Informant MR. JOHN W. HIMMELHEBER
(b) Address 3310 CARDENAS AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-48 (month) (day) (year)
(c) Cemetery or crematory ST. MARY'S
Location ANNAPOLIS, MD.

18 (a) Funeral director WEDEFELD & SON
(b) Address GREENMOUNT & 22ND

19 (a) JAN 2 - 1948 (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 June 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Dec 1947, to 1 Jan 1948, and that I last saw h[illegible] alive on 1 Jan 1948

Cause	Duration
Immediate cause of death: Cerebral Hemorrhage	1 day
Due to: Hypertensive cardio-vascular disease	10 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Allan Rose M.D.
Address Med Gen Hosp Date signed 1 June 48

68588 (2) Haschert X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered No. 68588

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Chesley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Elizabeth Haschert

3 (b) If veteran, name war — (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1867

8. AGE: Years	Months	Days	If less than one day
C. 80	8	11	hr. min.

9. Birthplace Steelton, Pa. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Catherine Regan
(b) Address 6 Chesley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 3 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Mark W. Bond's
(b) Address 7110 Belair Rd

19 (a) JAN 2 1948 (Date received by Registrar) Wilmington, Del. Registrar

V S 150

MEDICAL CERTIFICATION 38

20. DATE OF DEATH 12/31 1947, at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1947 to 12-31 1947 and that I last saw h[illegible] alive on 12/31 1947.

Immediate cause of death	Duration
Cerebral vascular accident	
Due to Hypertensive CVD	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M. D.
Address 1400 N Caroline St Date signed 12/31/47

FEMALE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

358589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 358589

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 S. Potomac St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 S. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Pfeifer

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-0823

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 13 1892

8. AGE: Years 55 | Months 8 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name John Pfeifer
13. Birthplace Germany

MOTHER 14. Maiden Name Anna Kreusslein
15. Birthplace Germany

16 (a) Informant Emma Herbeth
(b) Address 127 S. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director E. Walter May
(b) Address 669 N. Baldwin St.

19 JAN 2 - 1948 (Date rec'd by registrar) Waiting for Williams [illegible] Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31, 1947, at 1145 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to Dec 31 1947, and that I last saw h[illegible] alive on Dec 31 1947.

Immediate cause of death: Coronary Thrombosis — Duration 1 Day

Due to: Hypertension Sen. — 5 Yrs

Due to: —

Other Conditions: Diabetes — 3 Yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James F. Kavanaugh M.D.
Address 3614 Eastern Ave Date signed 1-2-48

94A James F. Kavanaugh

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

Registered No. 658590

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 Druid Hill Ave.
(c) Hospital or institution: 14 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Sinfield Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rosa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1889

8. AGE: Years 58 | Months | Days 13 | If less than one day hr. min.

9. Birthplace Surry Co. Va (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Samuel Price

13. Birthplace Augusta Co Va

MOTHER 14. Maiden Name Rosa Lee Tilley

15. Birthplace Mecklenburg Co. Va

16 (a) Informant Kyron Price

(b) Address Surry Co. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Family Lot

Location Wakefield, Va

18 (a) Funeral director Mrs. Lawrence H. Holland

(b) Address 165 Druid Hill Ave.

19 (a) JAN 2 - 1948 (Date rec'd by registrar) (b) Burial Permit No. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1948, at 10 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1947 to Jan 1 1948. and that I last saw him alive on 1-1-1948

Immediate cause of death	Duration
Coronary sclerosis	12 days
Due to Hypertension	
Due to Cardia was. caused	decision
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno. H. Williams M. D.

Address 1723 Druid Hill Ave Date signed 1-2-48

1900 Ltr

58591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 92B

Registered No. G58591

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 Brentman St.
(c) Hospital or institution: 15c
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Brentman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1874

8. AGE: Years 73 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Louisa Co. Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Moses Gilliam
13. Birthplace Louisa Co. Va

MOTHER
14. Maiden Name Hardinia Hunter
15. Birthplace Louisa Co. Va

16 (a) Informant Mrs. Lucy Smith
(b) Address 1505 Brentman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Greenlawn Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lenora M. Holland
(b) Address 1631 Druid Hill Ave

19 JAN 2 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27-1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-1947, to 12-22-1947, and that I last saw h[illegible] alive on 12-28-1947.

Immediate cause of death	Duration
mitral regurgitation	
Due to Hypertension	
Due to Renal disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard T. Jones M. D.
Address 800 N. Broadway Date signed 1/2/47

C58592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 94A

Registered No. C58592

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 N. Carey St
(c) Hospital or institution: 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 N. Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ROYAL J. HUGHES

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband~~/or wife: Mamie
6 (c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): 7/27/1889
8. AGE: Years: 58 Months: 5 Days: 1 If less than one day: hr. min.
9. Birthplace: Amherst, Va. (Town, county, and state)
10. Usual Occupation: Farmer
11. Industry or business:

FATHER
12. Name: John Hughes
13. Birthplace: Va.

MOTHER
14. Maiden Name: Anna Davie
15. Birthplace: Va.

16 (a) Informant: Mamie V. Hughes
(b) Address: 629 N. Carey St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: A.A. County, Md.
18 (a) Funeral director: Charles G. Cooper
(b) Address: 510-12 N. Carrollton Ave
19 JAN 2 - 1948 (b) Registrar (Date rec'd by registrar)

VS 159

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 28th 1947, at 11.30M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1941 to Dec 28 1947 and that I last saw h Mm alive on Dec 27 1947.

	Duration
Immediate cause of death: Coronary Occlusion	4 months
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature John & S. Cooper M. D.
Address 629 N. Carey St Date signed 12-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A58593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C58593

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Campbell
3 (b) If veteran, name war
3 (c) Social Security Account No. 220-05-7182

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22-1900

8. AGE: Years 47 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name John Campbell
13. Birthplace Md

MOTHER
14. Maiden Name Rose Gordon
15. Birthplace Md.

16 (a) Informant Samuel Ray
(b) Address Hyde Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3-48 (month) (day) (year)
(c) Cemetery or crematory Fork Meth.
Location Fork Md

18 (a) Funeral director Clarence E. Arthur
(b) Address Fork Md.

19 (a) JAN 2 - 1948 (Date rec'd by registrar) (b) Huntingtown Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1947, at 8:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23 1947 to Dec. 31 1947 and that I last saw h/ alive on Dec. 31 1947

Immediate cause of death	Duration
Generalized peritonitis	22 days
Due to Ruptured gastric ulcer	22 days
Due to	
Other Conditions Sub-phrenic abscess	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Ruptured gastric ulcer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Goldstein
Address WBGH Date signed 1/2/31

58594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 58594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Refer to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 N. Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 N. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Walter J. Bishop-Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma Bishop

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22-1884

8. AGE: Years 63 | Months 5 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name Thos. Bishop

13. Birthplace Balto. Md

MOTHER 14. Maiden Name Don't Know

15. Birthplace Balto. Md

16 (a) Informant Emma Bishop

(b) Address 621 N. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 48 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto Md

18 (a) Funeral director Welsh Funeral Home

(b) Address 2008 Eutaw St.

19 (a) JAN 2 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1947 at 12-15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1947 to Dec 31 1947 and that I last saw him alive on Dec 31 1947

Immediate cause of death: Acute Myocardial Insufficiency — Duration

Due to: Coronary Thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar Zeller, M.D.

Address 2739 Eastern Ave Date signed 12/31/47 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 058595

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson 4 (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Park Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Urban T. Linzey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Married (Mrs. Alice V. Linzey)

6 (b) Name of husband or wife Mrs. Alice V. Linzey
ALICE WHITTLE 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 08/19/80

8. AGE: Years	Months	Days	If less than one day
67	2	13	12 hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Court Stenographer
11. Industry or business

FATHER
12. Name Tobias Linzey
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Linzey URBAN
15. Birthplace Maryland

16 (a) Informant Mrs. Alice W. Linzey
(b) Address 537 Park Ave. - Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/48 (month) (day) (year)
(c) Cemetery or crematory Dignity Memorial Cemetery
Location Towson, Md

18 (a) Funeral director H. W. Meare & Son
(b) Address 805 N. Calvert St. -

19 JAN 2 1948 (Date rec'd by Registrar) (b) Huntington Willigus, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1-48 19 , at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 19 48, to 1-1 19 48, and that I last saw him alive on 1-1 19 48

Immediate cause of death Hypostatic pneumonia
antecedent heart disease
with congestive failure

Due to

Due to

Other Conditions Intestinal obstruction, partial
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Rankin Richard Brown M. D.
Address Union Memorial Hosp. Date signed 1-2-48

VS 150

G58596 (early)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G58596

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-5
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2243- Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER G. KREBS Jr

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-24-0220

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16-1927

8. AGE: Years 21 20 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Deck hand on Ships

11. Industry or business

FATHER
12. Name Walter C. Krebs. Sr.
13. Birthplace Littlestown Pa

MOTHER
14. Maiden Name Pearl Ruth Brown
15. Birthplace Annapolis Md.

16 (a) Informant Mrs. Walter C. Krebs Sr.
(b) Address 2243 Wilkins ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3-1948 (month) (day) (year)
(c) Cemetery or crematory Mem. Cathedral Cem.
Location Balto. Md.

18 (a) Funeral director Duane C. Zyler
(b) Address 1600 W. North Ave

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1947, at 7.40 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 4-1

(a) Date of injury 12-30-47 at 7 P. M.
(b) Where did injury occur? Arundel Co. Pier #3 Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell over-board.

23. Signature Earl L. Kay M.D.
Medical Examiner.
Date signed 12-31-47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C58597

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 Carlisle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James B. Macneal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Josephine C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/9/1867

8. AGE: Years 80 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired Mfg.

11. Industry or business Paint Business

FATHER
12. Name James B. Macneal
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Burgess
15. Birthplace Md

16 (a) Informant Mrs. Burgess Macneal
(b) Address 3406 Carlisle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto, Md

18 (a) Funeral director Loring Byers
(b) Address 5001 Park Heights Ave

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Filed by Mildred M. [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1, 1948, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4-1947 to 1-1-1948, and that I last saw h[illegible] alive on 1-1-1946.

Immediate cause of death	Duration
Arteriosclerotic cardio vascular disease	Several yrs.
Due to (a) Acute Heart Failure	24 hrs
Due to (b) Chronic myocarditis with decompensation	6 wks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lendon E Little M. D.
Address 10 W. Madison St Date signed 1-2-47

S-58598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

S-58598 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1005 W Fairmale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 W. Fairmale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. 219-01-4131

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1892

8. AGE: Years	Months	Days	If less than one day
55 56	0	3	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Pinkney Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Mary Brown
15. Birthplace Md

16 (a) Informant Rosa Bias
(b) Address 1005 W. Fairmale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director George D. Kilson
(b) Address 1303 Presstman St

19 JAN 6 1948 (Date rec'd by registrar) (b) Livingston Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1948, at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1947 to 1-4 1948.
and that I last saw her alive on 1-4 1948

Immediate cause of death	Duration
Hypertension Cardio-Renal Vas Culer with Dropsy	4
Due to	
Due to	2 Mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. F. Hatch M. D.
Address 1 Y K S Pk Date signed 1-7

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92A

Registered No. G58599

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 E. Madison St
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C Roberts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Helen O Roberts
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Aug 26, 1887

8. AGE: Years	Months	Days	If less than one day
60	4	5	hr. min.

9. Birthplace Sutherland Va
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Henry Roberts
13. Birthplace Sutherland va

MOTHER
14. Maiden Name unknown
15 Birthplace

16 (a) Informant Wilbur Roberts
(b) Address 1132 E. Lombard St

17 (a) Burial (b) Date thereof Jan. 4. 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sutherland Cem
Location Sutherland va

18 (a) Funeral director Elmer O Wilson
(b) Address 1000 Belmont Ave

JAN 3 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 12-26

20. DATE OF DEATH 1-1- 1948 at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1947 to 1-1 1948, and that I last saw h[illegible] alive on 12-29 1947.

Immediate cause of death Bronchio-pneumonia — Duration over 1 wk.
Due to
Due to
Other Conditions aortic insufficiency
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1500 E. Madison St Date signed 1/2/47 M.D.

107 Raymond Browne

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58600

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 50

Registered No. G58600

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 E. Lanvale Street
(c) Hospital or institution: 8.6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE BESSIE TAYLOR

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 175-10-4681

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James W. Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19-1884

8. AGE: Years 63 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace York, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Casper Klebish
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Eich
15 Birthplace Penna.

16 (a) Informant Mrs. Mabel C. Carver
(b) Address 1903 E. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (JAN 3 1948) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH January 1 1948 at 3.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1947 to Jan 1 1948 and that I last saw h~~e~~r alive on 12/31/47 19

Immediate cause of death: Carcinoma of Breast — Duration: 15 mos.
Due to:
Due to:
Other Conditions: Generalized Carcinomatosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius C. Block M.D.
Address 537 E Read Street Date signed 1/7/48

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G58601

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5206 Gwynn Oak Ave
(c) Hospital or institution: 28-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 83 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5206 Gwynn Oak Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fanny Rose Whitney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8 1864

8. AGE: Years	Months	Days	If less than one day
83	11	25	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name George H.Whitney
13. Birthplace New York N.Y.

MOTHER
14. Maiden Name Jane Harrison
15. Birthplace Ireland

16 (a) Informant Mary V.Whitney
(b) Address 5206 Gwynn Oak Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry P. Simmons
(b) Address 4204 Ridgewood Ave

19 JAN 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5 1948 at 4:52 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1947 to 12-31 1947 and that I last saw h[illegible] alive on 12-30 1947.

Immediate cause of death — Duration

Acute Cerebral Embolism Cardiac
Due to Mitral Regurgitation
Due to Arterio Sclerosis
Cardiac Hypertrophy
Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1-2-48

VS 150

G58602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G58602

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE ONPRINTING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 E. 25th St.
(c) Hospital or institution: 12-B
(d) Length of stay in ~~hospital or inst.~~ (yrs., mos., or days) ABOVE ADDRESS 26 YRS.
(e) Length of stay in Baltimore (yrs., mos., or days) 26 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATE T. BEDSWORTH

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOW
6 (b) Name of husband or wife: JEROME T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 7, 1861

8. AGE: Years 86 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name GEORGE PHILLIPS
13. Birthplace WYMOCA Co., MD.

MOTHER
14. Maiden Name OFFITT
15 Birthplace MD.

16 (a) Informant MRS. GOLDIE BOWERS
(b) Address 414 E. 25th St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/3/48 (month) (day) (year)
(c) Cemetery or crematory PARSONS CEMETERY
Location SALISBURY, MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address NORTH & PA. AVES., BALTO, MD.

19 (a) JAN 3 - 1948 (Date rec'd by Registrar) Waiting for Williams MD (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31/47, 19, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26th, 19 47. to Dec. 31, 19 47. and that I last saw her alive on Dec. 31st, 19 47.

	Duration
Immediate cause of death: Uremia	4 days
Due to: Chronic Interstitial Nephritis	unknown
Due to: ----------	
Other Conditions: Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas W. Hungerford MD
Address 401 E. 25th. St. Date signed 1/2/48.

G58603 Dr Brack a 4/25 pm

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58603 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Burgess Store Va (If outside city or town limits, write RURAL and give town)
(d) Street No. Burgess Store Va (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary King

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Luther M. King
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) 5/25/82

8. AGE: Years	Months	Days	If less than one day
65 years	7	7	hr. min.

9. Birthplace N. J. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edw Weddington
13. Birthplace N. J.

MOTHER
14. Maiden Name Mary Hood
15. Birthplace N. C.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/2/48 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Wm. J. Liebau & Son
(b) Address N. Pennsylvania Ave, Balto, Md.

JAN 3 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1948, at 1.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1947 to 1-2 1948, and that I last saw he alive on 1-2 1948

Immediate cause of death: Adenocarcinoma of Uterus c Metastases — Duration: 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Oct 29 1946
Major findings of operation: Adenocarcinoma of Fundus Uteri Grade III
of autopsy: Confirmed Above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Finney Hanson, M.D.
Address Johns Hopkins Hospital Date signed 1-2-48

G58604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G58604

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 W. Lafayette
(c) Hospital or institution:
19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 S Navris St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Murray

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-11-1874

8. AGE: Years	Months	Days	If less than one day
73	10	20	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William E Benner
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth W. Fuchs
15. Birthplace Germany

16 (a) Informant Mrs. Rose M. Wolfe
(b) Address 606 Ellerslie Ave

17 (a) 1-3-48 (Burial, cremation, or removal) (b) Date thereof 1-3-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore

18 (a) Funeral director William Cook Inc
(b) Address 1917 St Paul St

19 JAN 3 - 1948 (Date rec'd by registrar) Quinton for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1948, at 7.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1947 to Dec 30 1947, and that I last saw h[illegible] alive on Dec 30 1947.

Immediate cause of death	Duration
Acute Cardiac Dilitation	2 days
Due to Cardiac Vascular disease	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Harry Glassman M. D.
Address 753 W. Lafayette St Date signed Jan 3 1948

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58605 JL - 88693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home Address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfons Guacci

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1858

8. AGE: Years	Months	Days	If less than one day
89	7	21	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Mariano Guacci
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore Md.
18 (a) Funeral director Wilson & Son
(b) Address 1219 E. Fayette St.

1948 JAN 2 (Date rec'd by Registrar) (Signature of Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1944 to Dec. 21 1947, and that I last saw h. im alive on Dec. 21 1947.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Arteriosclerosis Heart Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. R. Dearborough M. D.
Address Balto. City Hosp. Date signed 1-2-47

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131A

Registered No. G58606

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 S. Ann St.
(c) Hospital or institution: 2-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 S. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Sheffield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hannah Sheffield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22 1871

8. AGE: Years 76 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER
12. Name James Sheffield
13. Birthplace Ireland

MOTHER
14. Maiden Name Rosabella Armstrong
15. Birthplace Baltimore Md.

16 (a) Informant Hannah Sheffield
(b) Address 218 S. Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Fa. North Ave.

18 (a) Funeral director Wm. Cook Expr.
(b) Address 1217 St. Paul St.

19 (a) JAN 3 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1st 1948, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1947, to 1-1- 1948, and that I last saw h[im] alive on 1-1- 1948.

	Duration
Immediate cause of death Chronic myocardial insufficiency	
arteriosclerotic heart	2
Due to Disease	
Chr. nephritis	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Mackelcan M. D.

Address 2220 Eutaw Pl. Date signed 1/2/48

VS 150

G58607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 947

G58607
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Chevrolet Plant -
(c) Hospital or institution: Broening H'way
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Mc Mechen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Autry H. Hales

3 (b) If veteran, name war: WORLD WAR II

3 (c) Social Security Account No: 217-14-3890

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: DORIS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 16 1910

8. AGE: Years	Months	Days	If less than one day
37	5	14	hr. min.

9. Birthplace KENLY, N. CAR.
(Town, county, and state)

10. Usual Occupation ASSEMBLY MAN

11. Industry or business CHEVROLET - GEN'L MOTORS

FATHER
12. Name RAIFORD A. HALES
13. Birthplace N. CAR.

MOTHER
14. Maiden Name SUDIE DARDEN
15. Birthplace N. CAR.

16 (a) Informant DORIS B. HALES
(b) Address 812 ALLENDALE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 3, 1948 (month) (day) (year)
(c) Cemetery or crematory U. S. NATIONAL
Location BALTIMORE, Md.

18 (a) Funeral director WILLIAM COOK INC.
(b) Address 1217 ST. PAUL ST.

19 JAN 3 - 1948 (Date rec'd by Registrar) (b) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1947 at 3 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Coronary Artery Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.

Date signed 12-31-47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G58608

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 Guilford Ave
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Naom Enson

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Jacob
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4-1856

8. AGE: Years 91 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Haines
13. Birthplace Carroll Co Md

MOTHER 14. Maiden Name Emmaline Barnes
15. Birthplace Carroll Co Md

16 (a) Informant Mr. Enson
(b) Address 1629 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Wellings Cook Inc
(b) Address 1717 St. Paul St.

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Interior for Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1948 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1948, to Jan. 1 1948, and that I last saw her alive on Dec. 1947.

Immediate cause of death Myocardial Insuff. | Duration 1 wk.
Due to Gen. Art. Sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sheldon Lankford M.D.
Address Druid Ridge Date signed 1/5/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157 B

G58609 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3512 Old York Road
(c) Hospital or institution: 9-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Old York Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Christine M. McCormick

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 8, 1943

8. AGE: Years	Months	Days	If less than one day
4	1	24	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Donald F. McCormick
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary M. Hart
15. Birthplace Baltimore, Maryland

16 (a) Informant Mary M. McCormick
(b) Address 3512 Old York Road

17 (a) Burial (b) Date thereof 1/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 JAN 2 1948 (Date rec'd by Registrar) Printing by Williams Printing Co.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1947 to Jan 2 1948, and that I last saw h[illegible] alive on Dec 31 1947.

Immediate cause of death: Cerebral Hemorrage — Duration: 10 Min.
Due to: Congenital Malformation
Due to: Hydrocephalus & Spinal Bifida.
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin Mortimer Jr. M. D.
Address 2706 St Paul St Date signed 1/4/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58610 - 115838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1138

Registered G58610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home Address (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy McComas Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1893

8. AGE: Years 54 | Months 1 | Days - | If less than one day hr. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Phillip Clanton Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Mattie Cuvney
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/47 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Roland Ave - Near 39th St

18 (a) Funeral director Frank H. Neural
(b) Address Pikesville, Md.

19 JAN 3 - 1948 (Date rec'd by registrar) (b) Arlington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1947, at 12.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1947 to Dec. 29 1947, and that I last saw h 1m alive on Dec. 29 1947.

Immediate cause of death Tuberculosis of Lungs, far advanced — Duration 8 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight W. Parks M. D.
Address Balt City Hosp Date signed 12-31-47

V S 150

G58611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G58611

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pan American Oil Co-
(c) Hospital or institution: Brooklyn, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Brooklyn Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY ENGLAND

3 (b) If veteran, name war #1

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elsie Klump

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) July 22, 1897

8. AGE: Years 50 | Months 5 | Days 9 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Stillsman

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs Elsie England
(b) Address 3610 Brooklyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem
Location Washington Blvd

18 (a) Funeral director John F Denning Inc
(b) Address 711 Light St.

19 (a) JAN 3 - 1948 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1947 at 8. a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to Passive congestion of liver, spleen, lungs, and brain.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-31-47

G58612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G58612 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 W. Biddle Street
(c) Hospital or institution: 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 W. Biddle Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH HOLLEY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1915

8. AGE: Years	Months	Days	If less than one day
32	3	16	hr. min.

9. Birthplace Norfolk, Va. (Town, county, and state)
10. Usual Occupation Singer
11. Industry or business

FATHER
12. Name Norman Holley
13. Birthplace Va.

MOTHER
14. Maiden Name Clara Johnson
15. Birthplace Va.

16 (a) Informant Clara Johnson
(b) Address 207 W. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Arbutus, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.
(c) Date JAN 3 1948 (registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31, 1947, at 10:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1947 to 12-31 1947 and that I last saw h~~e~~ alive on 12-31 1947

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Franklin O. Phillips
Address 1543 Penna. Ave. Date signed 1/2/48

58613

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 93D

Register 58613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Bradley St.
(c) Hospital or institution: 17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Bradley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter (Torain) Toran

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Annie Toran
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): 1897

8. AGE: Years: 50 | Months | Days | If less than one day: hr. min.

9. Birthplace: Roxboro N. C.
(Town, county, and state)

10. Usual Occupation: Laborer
11. Industry or business:

FATHER
12. Name: Anderson Toran
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Marrie ?
15. Birthplace: North Carolina

16 (a) Informant: Annie Toran
(b) Address: 614 Bradley St

17 (a) Burial (b) Date thereof 1/3/48
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Balto. Nat. Cemet.
Location: Maryland

18 (a) Funeral director: H. Lefstad
(b) Address: 911 Druid Hill Ave.

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1947, at 9:30 AM

21. I certify that I took charge of the remains described above, held an Inspection + Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardiovascular disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George G. Merrill M.D.
Medical Examiner.
Date signed 12/29/47

VS 151

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

C58614

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 Sterling St.
(c) Hospital or institution: 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 642 Sterling St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME J Phillips Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jennie Coleman

6 (c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years: 68 Months: Days: If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Unemployed

11. Industry or business

FATHER
12. Name ? Coleman
13. Birthplace Virginia

MOTHER
14. Maiden Name Auckie Kelson
15. Birthplace Virginia

16 (a) Informant Charles Skates
(b) Address 579 Oxford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director H. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) JAN 3 - 1948 (Date rec'd by registrar) Mortuary for Willis Hardesty

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1947 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-1945 to 12-30 1947 and that I last saw h[illegible] alive on 12-30 19 11 PM

Immediate cause of death: Chronic Myocarditis — Duration: 2 years
Due to:
Due to: Chronic Nephritis — Duration: 2 years?
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Calvin B. LeCompte M.D.
Address 113 N Caroline St Date signed 1/2/48

X

CHANGE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52A

G58615 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 ORKNEY RD
(c) Hospital or institution: 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 ORKNEY RD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY MAMIE C. FREBURGER

3 (b) If veteran, name war: N/O
3 (c) Social Security Account No.: N/O

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband ~~or wife~~ EDWARD G. FREBURGER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 31, 1873

8. AGE: Years	Months	Days	If less than one day
74	8	29	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name EDWARD JUNG
13. Birthplace GERMANY

MOTHER
14. Maiden Name CATHERINE SAUER
15. Birthplace GERMANY

16 (a) Informant HUSBAND
(b) Address 504 ORKNEY RD., BALTO, MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/3/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ LOUDON PARK
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address UNION & PA. AVES., BALTO, MD.

19 JAN 3 - 1948 (Date rec'd by registrar) (b) Huntington Nitkowski, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 30, 1947, at 11 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec — 1946 to Dec 30 1947 and that I last saw h.W alive on Dec 30 1947.

Immediate cause of death	Duration
Uraemia —	2 days
Due to Hypertension & Papilloma Bladder,	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Benman Koob M. D.
Address 2200 Garrison Blvd Date signed 1-2-48

VS 150

G58616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 149A

G58616 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 Bonaparte Ave
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 914 Bonaparte Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Holliday

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: Elmer C. Holliday
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 29. 1907

8. AGE: Years	Months	Days	If less than one day
40	8	2	hr. min.

9. Birthplace Pittsburgh Pa (town, county and state)
10. Usual Occupation Nurse
11. Industry or business H

FATHER
12. Name Bert B. Parsons
13. Birthplace Pa.

MOTHER
14. Maiden Name Lola Martin
15. Birthplace Pa.

16 (a) Informant Mr. Elmer C. Holliday
(b) Address 914 Bonaparte Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons Inc.
(b) Address Balto. Md. Keith & Pa. Aves

19 (JAN 3 - 1948) (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1947, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Dec 1947
and that I last saw Her alive on 12/28 1947

Immediate cause of death: Cerebral Thrombosis — Duration: 3 mos
Due to: Loss of Urine — 20 mos
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: None 1946
Major findings of operation:
of autopsy: Loss of Urine

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Lee Hamner
Address [illegible] Date signed 12/30/47
A. ADLER SOMMHEIMER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. G58617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible] N. Broadway
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Glen Arm
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Streett (MARY FLORENCE STREETT)

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: James A Streett
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov 7, 1873

8. AGE: Years 74 | Months 2 | Days 24 | If less than one day: hr. min.

9. Birthplace Balto. County Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robert M Francis
13. Birthplace Balto. County Md.

MOTHER
14. Maiden Name Eleanor Stones
15. Birthplace Balto. County Md.

16 (a) Informant (Son) Thomas Streett
(b) Address 1527 Falsworth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5. 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location HENRY SANDER & SONS. INC.

18 (a) Funeral director Baltimore Md.
(b) Address

19 JAN 3 - 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 19 47 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 a.m. 19 47 to Jan 1 p.m. 19 47, and that I last saw h[illegible] alive on Jan 1 19 47.

Immediate cause of death	Duration
Intestinal Obstruction.	about 1½ days.
Due to Volvulus, complete (at Terminal ileum)	
Due to	
Other Conditions Arteriosclerosis, general	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Volvulus, complete at Terminal Ileum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph D'Antonio M.D.
Address Church Home & Hosp. Date signed 1/2/48

G58618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G58618

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Avenue
(c) Hospital or institution: EDGEWOOD NURSING HOME 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wk.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Guilford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA A. BATES

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Edward Bates, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July-16-1880

8. AGE: Years	Months	Days	If less than one day
67	5	14	15 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Wilhelm
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Wörf
15 Birthplace Germany

16 (a) Informant Mrs. John Kohles
(b) Address 433 S. Ellwood Avenue

17 (a) Burial (b) Date thereof 1/3/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAKLAWN CEMETERY
Location BALTIMORE, MARYLAND

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 JAN 3 - 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH December 31 1947, at 5.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Sept 1947 to 31 Dec 1947, and that I last saw her alive on 31 Dec 1947.

Immediate cause of death	Duration
Hypertensive Cardiovascular Disease	10 yr.
Due to	
Due to	
Other Conditions Diabetes Mellitus, Cerebral Thrombosis old	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Hartzog Jr. M. D.
Address 202 E. Preston St Balto Date signed 3 Jan '48

93D

VS 150

B58619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered No. G58619

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 E. Hoffman St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Ida B. Boone

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James B. Boone
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1864

8. AGE: Years	Months	Days	If less than one day
83	11	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin Franklin Marshall
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Fairbank
15. Birthplace Maryland

16 (a) Informant Miss Lillian Boone
(b) Address 2420 E. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem. Location Northwood

18 (a) Funeral director Wm. E. O'Leary & Sons
(b) Address 2435 E. Monument St

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Awaiting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 19 48 at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 19 47, to Jan 2 19 48; and that I last saw her alive on Jan 1 19 48.

Immediate cause of death	Duration
Arteriosclerosis	
Heart Disease	
Due to	
Due to	
Other Conditions Generalized Arteriosclerosis Bilateral Broncho pneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. E. Fisher M. D.
Address Church Home & Hospital Date signed 1-5-48

G58620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G58620

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly. Physicians: please write correct age is especially important. DO NOT USE INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-2
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1161 Nanticoke (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HERBERT HICKMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-07-7717

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife MARGARETTE HICKMAN
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) APRIL 13, 1917

8. AGE: Years	Months	Days	If less than one day
30	8	17	hr. min.

9. Birthplace VIRGINIA (Town, county, and state)
10. Usual Occupation WELDER
11. Industry or business BOPPERS Co.

FATHER
12. Name HERBERT W. HICKMAN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name ETHEL BUE
15. Birthplace UNKNOWN

16 (a) Informant MARGARETTE HICKMAN
(b) Address 1161 NANTICOKE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-5-49 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET CEM.
Location FREDERICK AVE

18 (a) Funeral director Joseph F. Sanfaçon, Jr.
(b) Address 414 N. Franklintown Rd.

19 (a) JAN 3 - 1949 (Date rec'd by registrar) (b) Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1948, at 3.55a M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH CO poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-1-48 at 3 a. M.
(b) Where did injury occur? 1161 Nanticoke Balto.Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating Gas

23. Signature Earl L. Penger M.D. Medical Examiner
Date signed 1-1-48

VS 191

G58621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G58621

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 157
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 School Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1883

8. AGE: 64 | Months 11 | Days | If less than one day ____ hr. ____ min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Williams
13. Birthplace md

MOTHER
14. Maiden Name Jane Jackson
15. Birthplace md

16 (a) Informant Mary Logan
(b) Address 2320 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location md

18 (a) Funeral director George D. Kelson
(b) Address 2310 Presstman St

19 (a) JAN 3 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1948, at 2.20a M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Kruger M.D.
Medical Examiner.
Date signed 1-1-48

VS 181

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT FOLD, WRITE UNDER LINES, WITH UNFADING INK.

C58622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered C58622

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 School St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Collins (Lucinda)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Noah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name unobtainable

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Alice Gordon

(b) Address 729 School St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location md

18 (a) Funeral director Geo. U. Kelson

(b) Address 1303 Prestman St

19 (a) Jan 2 1948 (Date rec'd by registrar) (b) Cemetery or Williams Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1947, at 10.38 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Carl A. Royer M.D. (Medical Examiner)

Date signed 12-31-47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

Registered No. G58623

GM. 115790

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Bolton ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Carter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan ? - 1884

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name (D) ?
13. Birthplace ?

MOTHER
14. Maiden Name ? (D)
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn, Location Md

18 (a) Funeral director George H Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Thomas Stanton Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 - 1948, at 3.45AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 9 - 1947, to Jan. 1 - 1948, and that I last saw her alive on Jan. 1 - 1948

Immediate cause of death	Duration
Uremia	
Due to Renal, Cerebral Arteriosclerosis	
Arteriolonephrosclerosis	
Due to	
Other Conditions Pulmonary edema, Dilat.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Mural thrombus in aorta

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. T. Binford
Address Balt. City Hosp. Date signed 1-2-48 M. D.

G58624

BALTIMORE CITY HEALTH DEPARTMENT

Rubin CERTIFICATE OF DEATH 83 A

Registered No. G58624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 N. Pulaski St.
(c) Hospital or institution: 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Rubin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband ~~or wife~~ Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
76 75			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Victor Sther
13. Birthplace Russia

MOTHER
14. Maiden Name 2da ?
15. Birthplace Russia

16 (a) Informant Harry Rubin
(b) Address 1711 N. Pulaski St

17 (a) Burial (b) Date thereof 1 4 48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Rodgale
Location Hamilton ave + Philia Rd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1004-26 W North Ave.

19 (a) JAN 5 1948 (b) for Williams
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1948, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947, to Jan 2 1948, and that I last saw h. alive on Jan 2 1948.

Immediate cause of death	Duration
Cerebro Vascular Accident	2 wks
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward I. Kallins M. D.
Address 1849 W. North Ave Date signed Jan 5-48

G58625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

Registered No. G58625

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Levindale Home
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave
(c) Hospital or institution:
27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5809 Clover Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IRA ROSENBERG

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Male	White	Married

6 (b) Name of husband or wife Annette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1907

8. AGE: Years	Months	Days	If less than one day
40	4	1	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Cashier Ins Co

FATHER
12. Name Samuel Rosenberg
13. Birthplace New York N.Y.

MOTHER
14. Maiden Name Laura Baum
15. Birthplace Balto. Md

16 (a) Informant Annette Rosenberg
(b) Address 5809 Clover Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Registrar Wilson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2 1948 at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1947 to 1-2 1948 and that I last saw h[illegible] alive on 1-2 1948.

Immediate cause of death Bronchopneumonia — Duration
Due to Amyotrophic lateral sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Boyd M. D.
Address Levindale Home Date signed 1-2-48

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

~~G58626~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G58626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nora K. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widower

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 188[illegible]

8. AGE: Years	Months	Days	If less than one day
61	-	3	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elic Snell
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace Va

16 (a) Informant Mrs Pearl Cartwright
(b) Address 1403 E. Balto St Balto Md

17 (a) Burial (b) Date thereof Dec 31 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem
Location Baltimore Md

18 (a) Funeral director Leo J. Laroche
(b) Address 1701-03 N. Patterson Park

19 (a) JAN 3- 1948 (b) [illegible] for William [illegible] Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1947, at 10.07 A M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carlton Ryder M.D.
Medical Examiner
Date signed 12-29-47

G58627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G58627

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4313 Springwood Ave.,
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4313 Springwood Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MINNIE SAVAGE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Joseph D. Savage
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15th, 1877

8. AGE: Years 70 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Frederick Reubenkoenig
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. J.D. Savage
(b) Address 4313 Springwood Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/5/48 (month) (day) (year)
(c) Cemetery or crematory Immanuel Lutheran
Location Baltimore, Md.

18 (a) Funeral director Lasch Funeral Home
(b) Address 7401 Belair Rd.

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2nd 1948, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1947 to Jan. 2 1948, and that I last saw h[illegible] alive on Jan 1, 1948

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: Hypertension	15 years
Due to: Arteriosclerosis	15 years
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Daresch M.D.
Address 1 W. Oneida Ave. Date signed 1/3/48

VS 150

C58628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered C58628

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Colonial Ter.
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Keswick Rd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dudley Shoemaker

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 215-10-1078

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Ellenor Shoemaker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1887

8. AGE: Years	Months	Days	If less than one day
60	10	17	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joshua Shoemaker
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Florence Hey
15. Birthplace Pennsylvania

16 (a) Informant Hosp. Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1948 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md

18 (a) Funeral director Henry W. Kershner Sons
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1948, at 3.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1947 to Jan 1 1948 and that I last saw h.i.h alive on Jan 1 1948

Immediate cause of death	Duration
Carcinomatosis	About 1 year
Due to Carcinoma of Pancreas	
Due to	
Other Conditions Emphysema obstruction	

(Include pregnancy within three months of death)

Date of operation 12/27/47.
Major findings of operation None gross tumor
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Jenkins M.D.
Address Union Memorial Hosp. Date signed 1-2-48

VS 150

G58629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G58629

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 E Lanvale St
(c) Hospital or institution: 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 E. Lanvale (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Culbreth Hopewell Warner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Frederica Chapell
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 8 1867

8. AGE: Years 80 | Months 3 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Prince Frederick Md. (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER — 12. Name Rev Geo. Krebs Warner
13. Birthplace Balto Md

MOTHER — 14. Maiden Name Angelica C Hopewell
15. Birthplace St Marys Co. Md

16 (a) Informant Mrs. C H Hopewell Warner
(b) Address 15 E. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1948 (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem
Location Balto Md

18 (a) Funeral director Henry N Jenkins & Sons
(b) Address McCulloh & Orchard Sts

19 JAN 3 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1948 at 12 Mn

21. I certify that death occurred on the date above stated; that I attended deceased from — 1930 to Jan 2 1948 and that I last saw h[illegible] alive on Jan 2 1948

Immediate cause of death	Duration
Coronary Thrombosis	12 hrs.
Due to Coronary Sclerosis	Indefinite
Due to Generalized Arteriosclerosis	Indefinite
Other Conditions St Hemaplegia	10 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Nathaniel M Beck M. D.
Address 1006 E. 23rd St Date signed Jan 3-48

VS 3

...item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G58630

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. DO NOT WRITE OVERLAPPING, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Womens Hospital
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1881

8. AGE: Years	Months	Days	If less than one day
66	11	8	hr. min.

9. Birthplace Jamestown City, KANSAS
(Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name JAMES W. TAYLOR
13. Birthplace ALBANY, N.Y.

MOTHER
14. Maiden Name LYDIA FOLGER
15. Birthplace NEW YORK City

16 (a) Informant MR. WILLIAM M. TAYLOR
(b) Address PARK RIDGE, N.J.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 5, 1948 (month) (day) (year)
(c) Cemetery or ~~crematory~~ LOUDON PARK CEM.
Location BALTIMORE, MD

18 (a) Funeral director WM J. TICKNER & SONS INC
(b) Address NORTH & PA. AVES, Balto, MD.

19 JAN 3 - 1948 (Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH January-1-1948 19, at 8.10 P.M.

21. I certify that I took charge of the remains described above, held an Insp.&Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed 1-2-48

G58631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58631

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edgewood Nursing Home
(c) Hospital or institution: 6000 Bellona Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5Mos.

2. USUAL RESIDENCE OF DECEASED: Queen Anne
(a) State Md. (b) County Carolina Co.
(c) City or town Centreville Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antionette E. Warren

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Herbert H. Warren
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1879

8. AGE: Years 68 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Frank Emery
13. Birthplace Md.

MOTHER
14. Maiden Name Smith
15. Birthplace Md.

16 (a) Informant George N. Kenly
(b) Address 103 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 3. 48 (month) (day) (year)
(c) Cemetery or crematory Chesterfield Cemy
Location Centreville Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1200 Eutaw Place

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1948, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to Jan. 1 1948
and that I last saw her alive on 12/31 1948

Immediate cause of death: Cerebral Hemorrhage — Duration 2 years
Due to Hypertension — years
Due to Contusion & Laceration — years
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry M. A. Hansen M. D.
Address 20 E. Preston St. Date signed 1/2/48

Hansen X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No. G58632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 941 N. Dallas St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joshua Jenkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-4-1893

8. AGE: Years	Months	Days	If less than one day
55	3	26	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER 12. Name John Jenkins
13. Birthplace Md.

MOTHER 14. Maiden Name Cynthia Williams
15. Birthplace Md

16 (a) Informant ~~JOHNS HOPKINS HOSPITAL~~ Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A a County

18 (a) Funeral director Mrs Lottie A. Wirth Dept
(b) Address 1179 N. Carlton St

19 (a) JAN 3- 1948 (Date rec'd by registrar) (b) Hunting Tom Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1947, at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1947, to Dec 30 1947, and that I last saw h[illegible] alive on Dec 30 1947

Immediate cause of death	Duration
Hepato-renal failure	1 wk
Due to Cirrhosis	several yrs.
Due to.....	?
Other Conditions Intestinal obstruction (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation:.....
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Henry F. Bahnson
Address [illegible] Date signed 12/31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

958633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G58633

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S Chapelgate Ave
(c) Hospital or institution: Pine Crest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mell Osborne Forsythe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm Henry Forsythe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1882

8. AGE: Years 65 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Francis M Osborne
13. Birthplace Md.

MOTHER 14. Maiden Name Minnie Fletcher
15. Birthplace Md

16 (a) Informant Wm N Forsythe
(b) Address Sykesville Md.

17 (a) Burial (b) Date thereof 1-5-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Grove
Location Glenwood Md

18 (a) Funeral director F.C. Heyenbottom
(b) Address Ellicott City, Md

19 (a) JAN 3 1948 (b) [illegible] Williamsport Md
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 JAN 1948, at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to 2 JAN 1948.
and that I last saw h[illegible] alive on 2 JAN 1948.

	Duration
Immediate cause of death: Hypostatic pneumonia	
Due to: Generalized arteriosclerosis, with marked cerebral	
Due to: degeneration, + debility.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emil H. Henning Jr. M. D.
Address 4580 Edmondson Ave. Date signed 3 Jan 48

VS 150

058634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

Registered No. 058634

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2714 E. Oliver St.
(c) Hospital or institution: 8-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 E. Oliver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vincent Cieri, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-8938

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Cecilia (nee Walter)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1889

8. AGE: Years	Months	Days	If less than one day
58	7	19	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Cecilia Walter Cieri
(b) Address 2714 E. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road, Balto. Md.

18 (a) Funeral director Schimunek Funeral Home
(b) Address 2601-3-5 E. Madison Street

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1948, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Jan. 2 1948, and that I last saw him alive on Jan 2 1948

Immediate cause of death	Duration
Carcinoma of stomach	About 2 yrs.
Due to ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack L. Valentine M.D.
Address 1732 E. Broadway Date signed Jan. 3 1948

VS 150

G58635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193a

Registered No. G58635

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 430 N. Exeter St
(c) Hospital or institution: G.F.

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 430 N. Exeter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ella Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Randle Bostick
13. Birthplace S. C.

MOTHER
14. Maiden Name Sallie ?
15. Birthplace S. C.

16 (a) Informant John Mooney
(b) Address 430 N. Exeter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Comm
Location Brooklyn Md

18 (a) Funeral director Clay V. Welsh
(b) Address 101 Bantz Ave Huntington Park Md

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30 1947, at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29-1947, to 12-30 1947, and that I last saw h[illegible] alive on 12-30 1947.

	Duration
Immediate cause of death Acute Myocardial Infarction	1 Day
Due to Cerebral - Arteriosclerosis	2 days
Due to Hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Denney M. D.
Address 1420 E. Chase Date signed 1-2-48

G58636 B.O.A

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 106c

Registered No. G58636

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town Glenburnie (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leon H. White Jr
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9/19/46
8. AGE: Years 1 | Months 3 | Days | If less than one day ....hr. ....min.
9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Leon White Sr
13. Birthplace
MOTHER 14. Maiden Name Evelyne
15. Birthplace
16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brentleyn rd
18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Brantley ave
19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1947, at 5:20 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...
Immediate cause of death ACUTE EDEMA OF OBSTRUCTION — Duration
Due to LARYNGO-TRACHEITIS
Due to Accidental death due to natural causes approved by medical examiner Dave
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Williamson A. Spencer
Address Johns Hopkins Hosp Date signed 1/3/48

To be officially approved Howard J. Carlson M.D.

C58637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1207

Register No. C58637

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital 7-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 N. Bradford St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Ruffing

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Allene Ruffin
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) August 4, 1904

8. AGE: Years	Months	Days	If less than one day
43	3	27	.....hr. .....min.

9. Birthplace Petersburg Va (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER 12. Name George Ruffin
13. Birthplace Emporia Va

MOTHER 14. Maiden Name Otilo Ruffin
15. Birthplace Emporia Va

16 (a) Informant Allene Ruffin
(b) Address 516 N. Bradford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3, 1948 (month) (day) (year)
(c) Cemetery or crematory East View Cem
Location Petersburg Va

18 (a) Funeral director Elroy O. Wilson
(b) Address 10 [illegible] Beauty Ave

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 1947, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to.....

Other Conditions Syphilitic aortitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Earle Kryder M.D.
Medical Examiner.
Date signed 1-1-48

94a

G58638 BC-4F-001574 Ben Relief

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G55638 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette 263
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7Hrs.-10Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 13.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Brendan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William John Grueninger Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/2/48

8. AGE: Years | Months | Days | If less than one day: 7 hr. 10 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William John Grueninger
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Elinor Doris PerDieu
15. Birthplace Lynchburg Virginia

16 (a) Informant Mrs. R.P. Grueninger
(b) Address 1626 N. Bond St Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4-1948 (month) (day) (year)
(c) Cemetery or crematory Cokesbury Cemetery
Location Abingdon, Md.

18 (a) Funeral director Howard K. McComas & Sons
(b) Address Abingdon, Md.

19 JAN 3 - 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3- 1948 at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1948 to 1-3 1948, and that I last saw h[illegible] alive on 1-3 1948

Immediate cause of death	Duration
Respiratory Failure	
Due to Catheterism	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Fitton M.D.
Address Bon Secours Hosp Date signed 1-3-48

X

G58639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G58639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 W. Saratoga
(c) Hospital or institution: 42
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Baker.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife: Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/15/1894

8. AGE: Years	Months	Days	If less than one day
53	4	15	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Willis Wilks
13. Birthplace Va

MOTHER
14. Maiden Name Martha ?
15 Birthplace Va

16 (a) Informant Alfred Baker (Son)
(b) Address 618 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/48 (month) (day) (year)
(c) Cemetery or crematory Lipps Cemetery
Location Emporia, Va.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30th 1947, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1947 to Dec 28 1947. and that I last saw her alive on Dec 28 1947

Immediate cause of death: Carcinoma of uterus

Due to

Due to

Other Conditions: Exhaustion

(Include pregnancy within 3 months of death)

Date of operation Dec 27 '47

Major findings of operation: Carcinoma of uterus

Autopsy: No

Duration: Unknown / 1948 / 4 mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. Bestrughea M. D.
Address 1413 Druid Hill Ave Date signed Jan 1-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58640 JL - 116235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 58640

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 Homestead St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1887

8. AGE: Years	Months	Days	If less than one day
61	0	23 24	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Owen J. Murphy
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Brannon
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan. 5, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director Rita Windefeld
(b) Address 900 East Biddle St.

19 (a) JAN 2 - 1948 (b)
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1948, at 3.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 1947 to Jan. 1 1948, and that I last saw h alive on Jan. 1 1948

Immediate cause of death	Duration
Bronchogenic Carcinoma	
Due to	
Due to	
Other Conditions Metastases to Liver + extension to pericardium.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard T. Benford M. D.
Address Balt. City Hosp Date signed 1-2-48

C58641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered C58641

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 13-1
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore #17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 930 Chauncey Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Susie Cohen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed, or ~~divorced~~
Female	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/17/75

8. AGE: Years	Months	Days	If less than one day
72	9	16	15 hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Herman Earnest Dannenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Ernestine Sommerfeld
15. Birthplace Germany

16 (a) Informant Mr. Jack Cohen
(b) Address 2255 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-48 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnheimer Sons
(b) Address 1902 Eutaw Place

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Hunting for Williamsburg, Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2 1948, at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31/47 19 to 1/2/48 19, and that I last saw h~~e~~r alive on 1/2/48 19

Immediate cause of death Hypostatic pneumonia
Due to Fracture of suprarenal process.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. Barkley Pickard Brown M. D.
Address Union Memorial Hospital Date signed 1/2/48

Alt. Asst. Med. Corps. X
Union Memorial Hosp.

G58642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G58642

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lake Drive near Park Ave.
(c) Hospital or institution: 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Annadale Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES M. WINTERNITZ.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sadie B. Winternitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1878.

8. AGE: Years	Months	Days	If less than one day
69	3	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Louis Winternitz,
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Belle Wheatfield,
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Sadie B. Winternitz,
(b) Address Annadale Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore, Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1902 Eutaw Place

19 (a) JAN 3 - 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1947 (1948) at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1947 to Jan 2 1948
And that I last saw him alive on Jan. 2 1948

Immediate cause of death

Acute cardiac failure — Duration (1½ hrs)
Due to arteriosclerosis with hypertension — 30 mins 5 yrs
Due to
Other Conditions Cerebral hemorrhage — 5 yrs
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. Frederick Lentz M. D.
Address Temple Garden Apts Date signed 1/2/48

VS 150

G58643 BALTIMORE CITY HEALTH DEPARTMENT G58643
CERTIFICATE OF DEATH 8/a Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County MONTGOMERY
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Washington Grove
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cleveland Boyd SCHWARTZ

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Ruth Dowden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1884

8. AGE: Years	Months	Days	If less than one day
63	1	26	hr. min.

9. Birthplace Frederick County, Md.
(Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name Joseph Schwartz
13. Birthplace Maryland

MOTHER
14. Maiden Name Mollie Musgrove
15. Birthplace Maryland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 1/5/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Md

18 (a) Funeral director Ernest C Gaither
(b) Address Gaithersburg Md

19 (a) (Date received by registrar) Frantz & Williams, Mgrs Registrar

JAN 4- 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 19 48, at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 19 47 to Jan. 3 19 48, and that I last saw him alive on Jan. 3 19 48

Immediate cause of death	Duration
acute purulent meningitis	
Due to pneumococci	14 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. L. Lewis, Jr. M.D.
J. L. Lewis, Jr.
Address Marine Hosp. Date signed 1/3/48

G58644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G58644 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413- Anchor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE HOFFMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/29/1925

8. AGE: Years 22 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore. (Town, county and state)

10. Usual Occupation Filling Sta Truck Driver

11. Industry or business

FATHER
12. Name Geo. W. Hoffman
13. Birthplace Balto.

MOTHER
14. Maiden Name Nora R. Burke
15. Birthplace N.Y.

16 (a) Informant Family
(b) Address Same.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-5-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn.

18 (a) Funeral director J. W. Cleary
(b) Address 302 S. Eutaw St.

19 (a) 1-3-1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3, 1948, at 6.20 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Burns
2nd & 3rd Degree 90% Body Surface

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 24/2

(a) Date of injury 12-30-47 at 4 A.M.
(b) Where did injury occur? Amoco Gas Station-Jackson St. Key Highway, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Explosion-gasoline

23. Signature Earle Royer, M.D. Medical Examiner.
Date signed 1-3-48

VS 151

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Kelly Dist. 2

G58645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 52B

G58645 Registered No. 446900

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County York County
(c) City or town Delta R.F.D. #1
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel C. Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
41 years			hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward C. Snyder
13. Birthplace Pa

MOTHER 14. Maiden Name Elizabeth Rigdon
15. Birthplace Pa

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 7 48 (month) (day) (year)
(c) Cemetery or crematory Brogueville Pa
Location York Co. Pa.

18 (a) Funeral director Hubert P. Watkins
(b) Address Delta, Pa.

19 (a) (Date received by registrar) (b) Registrar

JAN 4 '48 BS 150

Waiting for Attending MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3-1948, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1947 to 1-3 1948.
and that I last saw him alive on 1-3 1948.

Immediate cause of death	Duration
Surgical Shock	24 hrs
Due to Volvulus of intestine	24 hrs
Due to	
Other Conditions Cancer of Bladder c Exstrophy (Include pregnancy within 3 months of death)	

Date of operation Jan 2, 1947
Major findings of operation: Cancer Bladder, Exstrophy
of autopsy: Same plus volvulus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Terry B. Ludwig M. D.
Address Johns Hopkins Hosp. Date signed 1/4/47

X

G58646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G58646 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4003 Chatham Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4003 Chatham Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Weiner

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-48 (month) (day) (year)
(c) Cemetery or crematory Mishkon Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Pl.

19 (a) (Date received by registrar) (b) Registrar

JW S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 1 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1947 to Jan. 1, 1948. and that I last saw h[illegible] alive on Jan. 1, 1948.

Immediate cause of death Carcinoma Pancreas — Duration about 3 mos.
Due to —
Due to —
Other Conditions Metastases.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Spirt M. D.
Address 1810 Eutaw Pl. Date signed 1/2/48.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58647 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) Yr
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB MOLITZ

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Fredon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Hanzah
15. Birthplace Russia

16 (a) Informant Mrs Anna Levinson
(b) Address 3528 Virginia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-48 (month) (day) (year)
(c) Cemetery or crematory Levindale Mt Carmel
Location
18 (a) Funeral director Hall Lewis Inc
(b) Address 2106 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1948 at 11 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1947 to 1-3 1948 and that I last saw h.i.m alive on 1-3 1948.

Immediate cause of death	Duration
Chronic cardio vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Vogel M. D.
Address Levindale Home Date signed 1-3-48

150

Transcriber Williams, Md

G58648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G58648

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 West North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 West North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Schwartz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Hungary
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name David
13. Birthplace Hungary

MOTHER
14. Maiden Name Rebecca
15. Birthplace Hungary

16 (a) Informant Bertha Schwartz
(b) Address 704 W. North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-48 (month) (day) (year)

(c) Cemetery or crematory Mishkan Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2-1948 at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7, 1947 to Jan 3 1948 and that I last saw him alive on Jan 3, 1948

Immediate cause of death: Carcinoma of Stomach with Extensive Intra-abdominal Metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation August 19 1947

Major findings of operation: Carcinoma of Stomach with Extensive Intra-abdominal Metastases

Findings of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sigmund Goldberg

Address 622 W. North Ave Date signed 1-5-48

USCO S 150

G58649 BALTIMORE CITY HEALTH DEPARTMENT G58649

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 N. Payson
(c) Hospital or institution: Sinai Hospital, No
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Weems

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida Weems
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/74

8. AGE: Years	Months	Days	If less than one day
73	7	13	..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Store Manager
11. Industry or business

FATHER
12. Name James Weems
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Margaret Stengel
15 Birthplace Balto Md

16 (a) Informant Mrs. J. H. Weems
(b) Address 319 N Payson St

17 (a) Burial (b) Date thereof 1/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet.
Location Balto. Md.

18 (a) Funeral director Lansburgh Funeral Home
(b) Address 7401 Belair Rd.

19 (a) JAN 1948 (b) Date rec'd by Registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/x 1948, at 0 o'clock M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1948, to 1/x 1948 and that I last saw h[illegible] alive on 1/x 1948.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Bronchopneumonia - old organic valvular

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 1/3/48 M. D.

PRINT NAME PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

107

G58650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G58650 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Rolling Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma V. Foss — Emma V. Foss

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-5735-A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William H. Foss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1870

8. AGE: Years	Months	Days	If less than one day
77	9	7	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife — None

11. Industry or business

FATHER
12. Name William H. Maxwell
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte Rhoads
15. Birthplace Md.

16 (a) Informant Mr. George E. Foss
(b) Address 1513 S. Rolling Rd., Relay

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5th, 19 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wilkes Lamonaco
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date received by Registrar) (b) Burlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 January 1948, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Dec 1947, to 2 Jan 1948, and that I last saw h[illegible] alive on 1 Jan 1948

Immediate cause of death: Cardiac Failure — Duration:
Due to: Arteriosclerotic Heart Disease
Uremia
Due to
Other Conditions: Rectal Bleeding, etiology undetermined
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Hamill M D
M. D.
Address St. Agnes Hosp. Date signed Jan 2, 1948

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 179 X

G58651
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3337 Avondale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward W. Boblitz (BOBLETZ)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Jane E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1913

8. AGE: Years 34 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business

FATHER
12. Name William Boblitz
13. Birthplace Hampstead, Md.

MOTHER
14. Maiden Name Hattie V. Mills
15. Birthplace Front Royal, Va.

16 (a) Informant Mrs. Hattie V. Peregoy
(b) Address 5241 Linden Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director William Cook, Inc.,
(b) Address 1217 St. Paul Street

19 (a) 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1948, at 3.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Exposure
Due to methyl alcohol poisoning

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 1-3-48

VS 181

G58652 — BALTIMORE CITY HEALTH DEPARTMENT — G58652 Registered No.

CERTIFICATE OF DEATH 13a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2232 Hennerman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2232 Hennerman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oliver R Casey

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex: Male — 5. Color or race: White — 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frances Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 1886

8. AGE: Years 61 | Months 7 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name Samuel B Casey
13. Birthplace Baltimore Md

MOTHER — 14. Maiden Name Benezine Johnson
15. Birthplace Md

16 (a) Informant Matilda Watts
(b) Address 1117 Roche Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director Wilson Johnson
(b) Address 1217 Pennsylvania Ave

19 (a) (Date received by registrar) (Signature of registrar) Registrar

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1948 at 2:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Dec 1947 to 2 Jan 1948, and that I last saw h. alive on 2 Jan 1948

Immediate cause of death: Myocardial failure — Duration: 4 days 5 minutes
Due to: Hypertensive arteriosclerotic cardiovascular disease
Due to: Hypertensive arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Johnson M. D.
Address 1513 W. Mulberry St Date signed 6 Jan 48

G58653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 95 B

G58653 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2612 Maryland Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2612 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Loughran Wilson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) ~~Single~~, married, widowed, or ~~divorced~~ Widow

6 (b) Name of husband or wife Ralph Newton Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27 1880

8. AGE: Years 67 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace New York N.Y.
(Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Loughran
13. Birthplace Ireland

MOTHER 14. Maiden Name Elizabeth Hanson
15. Birthplace New York N.Y.

16 (a) Informant Mrs Estelle W McKenzie
(b) Address 2612 Maryland Ave

17 (a) Removal (b) Date thereof Jan 5 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Blandale
Location Blandale Annex

18 (a) Funeral director Bertrand Dyer
(b) Address 2224 N. Charles St.

19 (a) (Date rec'd by registrar) (b) Registrar

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1948 at 11 29 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 28 1947 to 1 3 1948 and that I last saw her alive on 1 2 1948.

Immediate cause of death Heart failure — Duration 4 yrs

Due to Rheumatic Heart Disease —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Maurice L. Slemp M. D.
Address 1431 Eutaw Pl Date signed Jan 3 1948

Huntington Williams, M.D.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Found - Railroad Tracks - Johnson Street

Registered No. G58654

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dof
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 S. Charles St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard E. CROKE

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Germaine A. Croke
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) July 4, 1904

8. AGE: Years 43 | Months 5 | Days 28 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Day Laborer
11. Industry or business

FATHER
12. Name Richard Croke
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Feaver
15. Birthplace Ireland

16 (a) Informant Germaine A. Croke
(b) Address 1129 Riverside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. 2 Lo

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S Charles St

19 JAN 4 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1948 at 1 25 A.M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner.)
Date signed 1/2/48

VS 191

G58655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193e

G58655
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please fill in the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 S. Augusta Ave
(c) Hospital or institution:
Jewish Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 S Augusta Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Healy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 1857

8. AGE: Years 91 | Months | Days | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mathew Healy
13. Birthplace Irland

MOTHER
14. Maiden Name Mary Cunningham
15. Birthplace Irland

16 (a) Informant Mrs. Anna T. Healy
(b) Address 202 S. Augusta ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5 1948 (month) (day) (year)
(c) Cemetery or crematory Mary Cathedral
Location Old Frederick Rd

18 (a) Funeral director Harry H Wright
(b) Address 1801 Edmondson Ave

4-1948 (Date rec'd by registrar) (b) Harry Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 January 1948 at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to 1 Jan 1948 and that I last saw h- alive on 31 Dec 1947

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic Cardio. Vascular Disease	
Due to	
Other Conditions Hypertrophic Arthritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Hamill M.D. M. D.
Address Jewish Memorial Hosp. Date signed 1 Jan 48

G58656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G58656 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2747 Barclay ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Fifty Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2747 Barclay ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie E Schmitt

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-2235

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ John J. Schmitt

(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 4/27/1907

8. AGE: Years 40 | Months 8 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Thomas O'Brien

13. Birthplace Balto Md

MOTHER 14. Maiden Name Elizabeth Affayeux

15. Birthplace Baltimore Md

16 (a) Informant John J. Schmitt

(b) Address 2747 Barclay ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location 4300 Belair Road

18 (a) Funeral director Martin W. E. Dippel Son

(b) Address 37 S. Ann St

19 (a) Date received (registrar) (b) Registrar

JAN 6 1948 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1st 1948, at 6:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1 1947, to Dec 31 1947, and that I last saw h[illegible] alive on Dec 31 1947.

Immediate cause of death Sympho-Sarcoma — Duration 3 years.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Kaden M. D.

Address 2306 Eutaw Pl. Date signed 1-2-48

F Transcript G58657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G58657 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. (The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2306 Annapolis Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Annapolis Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Ida Nuesslein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Henry F. Nuesslein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9. 1891

8. AGE: Years 56 | Months 1. | Days 28 | If less than one day hr. min.

9. Birthplace Arundel Co. - Brooklyn
(Town, county, or state)

10. Usual Occupation Home Duties

11. Industry or business

MOTHER / FATHER

12. Name George Brown

13. Birthplace Balto. Md.

14. Maiden Name Unknown.

15. Birthplace Balto Md.

16 (a) Informant Henry F. Nuesslein
(b) Address 2306 Annapolis Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5-1948 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location

18 (a) Funeral director Ingmie Cook & Offer
(b) Address 1600 W. North Ave

19 (a) Jan 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1948 at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to Jan 2 19 48 and that I last saw her alive on Dec 31 19 47

Immediate cause of death: Coronary Thrombosis — Duration 1 year

Due to: Diabetes Mellitus — Duration 2 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 2301 Annapolis Date signed 1/3/47

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

G58658 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mrs. Wheeler - Nursing home
(c) Hospital or institution: 1700 Park Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Wheelers Nursing home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma G. Sexton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas H. Sexton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29 1857

8. AGE: Years: about 90. | Months: 2 | Days: 4 | If less than one day ..... hr. ..... min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Eugene Grosh
13. Birthplace

MOTHER 14. Maiden Name Marie Witt
15. Birthplace Balto - Md

16 (a) Informant Mrs. Alice Wheeler
(b) Address 1700 Park Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan. 3 - 1940 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto

18 (a) Funeral director Isaac Bosley Lyden
(b) Address 1600 W. North Ave

19 (a) Jan 4 1940 (Date rec'd by registrar) (b)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 2 1940 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Jan 2 1940 and that I last saw he alive on Jan 1 1940.

Immediate cause of death	Duration
Cardio - Vascular Hypertension Disease	12 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. C. Dodd M. D.
Address 2108 St Paul St Date signed 1/3/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58659 BALTIMORE CITY HEALTH DEPARTMENT G58659
CERTIFICATE OF DEATH ✓ 93D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 Edgewood St.
(c) Hospital or institution: 20-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Edgewood St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E. Brannan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Late John J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1870

8. AGE: Years 77 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Michael Carroll
13. Birthplace Ireland

MOTHER 14. Maiden Name Frances Baker
15. Birthplace Md.

16 (a) Informant Edward J. Brannan
(b) Address 523 Edgewood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5/48 (month) (day) (year)
(c) Cemetery or crematory Mem. Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry A. Little
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2. 1948, at 7:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Nov 1947, to 2 Jan 1948, and that I last saw h.e.r. alive on 31 Dec 1947

Immediate cause of death: Hypertensive, arteriosclerotic cardiovascular disease — Duration 10 yrs +
Due to
Due to
Other Conditions Fractured L. Hip — 1946
(Include pregnancy within 3 months of death)
Date of operation 1946 & 1947
Major findings of operation: Two attempts at pinning L. hip
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 20 E. Preston St Date signed 14 Jan 48

VS 150

G58660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63C

Registered No. G58660

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince Georgie
(c) City or town Hyattsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 4910 Rhode Island Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ann Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-28-47

8. AGE: Years | Months: 7 | Days: 6 | If less than one day: hr. min.

9. Birthplace D.C. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER — 12. Name Sydney Daniels

13. Birthplace Md.

MOTHER — 14. Maiden Name Laura M. Gibson

15. Birthplace Va

16 (a) Informant Records JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Hyattsville (Burial, cremation, or removal) (b) Date thereof Jan 4/48 (month) (day) (year)

(c) Cemetery or crematory Hyattsville Int

Location Hyattsville Md

18 (a) Funeral director Thomas Joseph Sons

(b) Address Hyattsville Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 65

20. DATE OF DEATH Jan. 3 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1947, to Jan 3 1948, and that I last saw h[illegible] alive on Jan 3 1948

	Duration
Immediate cause of death: Respiratory failure	immediate
Due to: Aspiration pneu.	1-2 wks.
Due to: Carcinoma	7 mos.
Other Conditions: Congenital heart disease (Include pregnancy within 3 months of death)	7 mos.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Engler Jr. M. D.

Address The Johns Hopkins Hosp. Date signed 1-3-47

VS 150

G58661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 B

G58661 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2034 Eastland Ave
(c) Hospital or institution: 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2034 Eastland Av (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Berkol

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1881

8. AGE: Years 66 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Varvina

13. Birthplace Germany

MOTHER 14. Maiden Name Caroline Puchalski

15. Birthplace Germany

16 (a) Informant Roland J. Berkol

(b) Address 3239 Shannon Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-48 (month) (day) (year)

(c) Cemetery or crematory Dodd Hill

Location Baltimore Md

18 (a) Funeral director Frank Brochidas

(b) Address 900 E. Lebanon St

JAN 5 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1948, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1947 to Jan 2 1948, and that I last saw her alive on Jan 2 1948.

Immediate cause of death: Carcinoma of Uterus — Duration: 1 year

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide N.O.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pokorny M.D.

Address 2201 E Madison Date signed 1/3/48

X

G58662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

✓ G58662 Registered No. 5698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 Gold St.
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) over 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give County)
(d) Street No. 622 Gold St (If rural give location)
(e) Citizen of foreign country? Cno (Yes or No) If yes, name country

3 (a) FULL NAME Charles Hawkins Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-20-9924

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1888

8. AGE: Years 59 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Bryantown, Md. (Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business

FATHER 12. Name Washington Hawkins

13. Birthplace Bryantown, Md.

MOTHER 14. Maiden Name Mary Brawner

15. Birthplace Bryantown, Md.

16 (a) Informant Mrs. Lena A. Hawkins

(b) Address 622 Gold St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5, 1948 (month) (day) (year)

(c) Cemetery or crematory Family Lot

Location Compton, Md.

18 (a) Funeral director Mrs. Geo. A. Hall

(b) Address 1631 Druid Hill Ave

19 JAN 5 - 1948 (Date rec'd by registrar) (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 — 31 — 1947, at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11 — 1947 to 12 — 31 1947, and that I last saw him alive on 12 — 31 — 1947

Immediate cause of death: Pernicious Anemia — Duration: Unknown

Due to:

Due to:

Other Conditions: Myocarditis, Chronic Pulmonary T.B. (Include pregnancy within 3 months of death) — Unknown

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank L. Saunders M. D.

Address 1029 N. Stricker Date signed 1-1-48

73 A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48A

Registered No. G58663

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2124 Boyd St.
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 Boyd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth M. Gillmann

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Ewald Gillmann
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Mar 30, 1896

8. AGE: Years	Months	Days	If less than one day
51	9	2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John Zieler
13. Birthplace Germany.

MOTHER
14. Maiden Name Margaret Weidner
15 Birthplace Germany.

16 (a) Informant Ewald Gillmann
(b) Address 2124 Boyd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1948 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Thos. John W. Gentel & Son
(b) Address 5311 Edmondson Ave.

19 JAN 5 1948 (Date rec'd by registrar) (b) Thomas Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1948, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1946 to 1/1 1948, and that I last saw her alive on 1/1 1948.

Immediate cause of death Carcinoma of intest & appendages general metastases — Duration 1 3 mos

Due to —

Due to —

Other Conditions None

(Include pregnancy within three months of death)

Date of operation 12/6/46

Major findings of operation: Carcinoma of intest & appendages

of autopsy: None made

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Leavell M.D.
Address 926 Hanover St. Date signed 1/5/48

V S 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G58664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2129 Annapolis Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Creamer

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-05-4707

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary A. Creamer
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Dec 13 - 1900

8. AGE: Years	Months	Days	If less than one day
47	0	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Wholesale Produce

FATHER
12. Name John Creamer
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Catherine Kreamer
15. Birthplace Baltimore Md

16 (a) Informant Mary A. Creamer
(b) Address 2129 Annapolis Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co. Md

18 (a) Funeral director M. V. Mrs. John W. Tuppel & Son
(b) Address 5311 Edmondson Ave

19 (a) JAN 5 - 1948 (Date rec'd by registrar) (b) Washington Wilkinson, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1948, at 11:55 A M

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 1/2/48

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register No. C58665

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232- Argyle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zollie A. HAWKINS

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-9381

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-5-97

8. AGE: Years 50 51 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Weldon, N. C. (Town, county, and state)

10. Usual Occupation Barber - 409 Wilkens

11. Industry or business Hair Barber Shop

FATHER
12. Name Charles Hawkins
13. Birthplace N. C.

MOTHER
14. Maiden Name Sallie Ann Mitchell
15. Birthplace N. C.

16 (a) Informant Miss Maude M. Hawkins
(b) Address 515 Juniella St. Pittsburgh Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-48 (month) (day) (year)
(c) Cemetery or crematory W. A. Lowe
Location Weldon, N. C.

18 (a) Funeral director Charles L. Lowe
(b) Address 802 Madison Ave.

19 (a) (Registrar's signature) (b) Huntington Williams, M.D.

JAN 5 1948

vs 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1948, at 10.35 a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured skull
Intracranial hemorrhage
Contusion of brain
Bronchopneumonia
Other Conditions: Fatty degeneration of liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-31-47 2 p. M. 14/2
(b) Where did injury occur? Division & Lafayette Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian- struck by auto

23. Signature Geo. H. Merrill M.D. Medical Examiner.
Date signed 1/3/48

658666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G58666

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Levendale 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levendale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Weiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 58 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Abrahow
13. Birthplace Russia

MOTHER
14. Maiden Name Fanyie
15. Birthplace Russia

16 (a) Informant Meyer Weiner
(b) Address Levendale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt. Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 210 Eastern Place

19 (a) JAN 5 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1948 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1947 to 1-4 1948, and that I last saw h er alive on 1-4 1948

Immediate cause of death	Duration
Carcinoma of Gall Bladder & Liver	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin
Address Levindale Date signed 1/5/48

VS 150

G58667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G58667
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 Hollins St
(c) Hospital or institution: 19-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie O. Bowers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Wm H. Bowers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 1888

8. AGE: Years 59 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Heusler
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Charles E. Bowers
(b) Address Route 14 Bal 346 Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6-1948 (month) (day) (year)
(c) Cemetery or crematory Woodbury M. E. Church Cem
Location Reisterstown Md

18 (a) Funeral director Robt C. & B. M. Walker
(b) Address Pikesville Md

19 (a) JAN 6- 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1948 at 6 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 1948 to 1/3 1948 and that I last saw h alive on 11 31 1947

Immediate cause of death Arteriosclerotic Heart Disease — Duration 2 yrs

Due to

Due to

Other Conditions Cerebral Hemorrhage — Duration 2 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1630 Wilkens Date signed 1/5/48

VS 150

C58668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125A

Registered No. C58668

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33[illegible] Calvert Street
(c) Hospital or institution: Union Memorial Hospital 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3440 Parklawn Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. [illegible] J. Santora (Lillian A.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	

6 (b) Name of husband or wife E. J. Santora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1912

8. AGE: Years	Months	Days	If less than one day
35	11	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name James Zelanka
13. Birthplace Balt., Md.

MOTHER
14. Maiden Name Lillian Blazek
15. Birthplace Balt., Md.

16 (a) Informant Mr. Edward Santora
(b) Address 3440 Parklawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos. J. Sterr & Son
(b) Address 3001 Pentwood Ave

19 (a) [illegible] 6 1948 (b) [illegible] (Registered by [illegible]) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1948, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1948 to Jan. 3 1948, and that I last saw h[illegible] alive on Jan. 3 1948.

Immediate cause of death	Duration
Liver failure	
Due to acute yellow atrophy	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel D Buck M.D.
Address Union Memorial Hospital Date signed 1/3/48

VS 150

C58669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. C58669

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St 16-2
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Smithson St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph W. Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 49 yr. | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Charles Co. MD
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name — Wells
13. Birthplace Charles Co. Md.

MOTHER
14. Maiden Name Louise Bailey
15. Birthplace — Md.

16 (a) Informant Louise H. Arms
(b) Address 1320 Smithson St

17 (a) Burial (b) Date thereof 1/5/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. National
Location Frederick Rd.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 927 N. Mount St.

19 (a) 1/5/48 (b) Thomas [illegible] Williams, M.D.
(Filed) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1948, at 5-5-9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1948 to 1/2 1948
and that I last saw he alive on 1/2/48 1948

Immediate cause of death: Cerebral Hemorrhage — Duration: ?

Due to: Hypertension

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Gamer
Address 1514 Division St Date signed 1/2/48

VS 150

G58670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G58670

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital 166
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 738 Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Chiaramonte

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna Chiaramonte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21 1889

8. AGE: Years	Months	Days	If less than one day
58	2	13	hr. min.

9. Birthplace Marsala Italy (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business Shoemaker Shop

FATHER
12. Name Pietro Chiaramonte
13. Birthplace Italy

MOTHER
14. Maiden Name Maria ?
15 Birthplace Italy

16 (a) Informant Anna Chiaramonte (wife)
(b) Address 738 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7/1948 (month) (day) (year)
(c) Cemetery New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Traull Della Rocca
(b) Address 52[illegible] Morley St.

19 (a) JAN 5 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3 1948, at 12 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1947, to 1/3 1948, and that I last saw h[illegible] alive on 1/3 1948.

Immediate cause of death Hemorrhage from gastro-ulcer

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Laurence Cookson - Wm Fineroth

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1/7/48

VS 150

+ Norman Mann

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered 058671

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1734 Poplar Grove St.
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) **FULL NAME** Edith Mary Barnes

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: WILLIAM B.
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 12/18/1863

8. AGE: Years: 84 | Months: 0 | Days: 15 | If less than one day: ____ hr. ____ min.

9. Birthplace: BRISTOL, ENGLAND (Town, county, and state)

10. Usual Occupation: HOUSEWIFE

11. Industry or business: —

FATHER
12. Name: DAIRD PETERS
13. Birthplace: ENGLAND

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: "

16 (a) Informant: MR. ROBERT BARNES - SON
(b) Address: 2109 SIDNEY AVE. BALTO, MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 1/6/48 (month) (day) (year)
(c) Cemetery or crematory: EPISCOPAL CHURCH CEM.
Location: TAYLORS ISLAND, MD.

18 (a) Funeral director: WM. J. TURNER & SONS INC.
(b) Address: NORTH & PA. AVES. BALTO., MD.

19 (a) JAN 5 - 1948 (b) [illegible] Registrar
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3rd Jan 1948, at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Jan 1948, to 3rd Jan 1948, and that I last saw her alive on 3rd Jan 1948.

Immediate cause of death	Duration
Acute myocardial failure	
Severe Secondary Anemia	
Due to Carcinomatosis, intestine	7
Due to	
Other Conditions Generalized arteriosclerosis	
Senility (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph E. Muse Jr. M. D.
Address 3311 St. Paul St. Date signed 1/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G58672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St.
(c) Hospital or institution: Home for Incurables 165
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 + 18
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 W. Hanvale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME Katherine F. Tolson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F.
5. Color or race: W.
6 (d) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ashby Tolson
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1870

8. AGE: Years 77 | Months 3 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Frederick
13. Birthplace Germany

MOTHER
14. Maiden Name Helena Winkler
15. Birthplace Germany

16 (a) Informant Records of Home for Incurables
(b) Address 700 W. 40th Street Baltimore, Md

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/6/48 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN CEMETERY
Location BALTIMORE CO. MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address NORTH PK. AVES., BALTO., MD.

19 (a) JAN 5 - 1948 (Date rec'd by registrar) (b) [signature] Registrar

VE 8

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 3rd 1948, at 4:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15th 1947, to Jan. 3rd 1948, and that I last saw h[illegible] alive on Jan. 2nd 1948

Immediate cause of death: Recurrent Cerebral Hemorrhage — Duration: 16 days
Due to Hypertensive Cardiac Vasc. Dis. — Unknown
Due to ____
Other Conditions ____
(Include pregnancy within 3 months of death)
Date of operation ____
Major findings of operation ____
of autopsy? ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature Thomas Conrad Wolf
Address 11 E. Chase St. Baltimore 2 MD. Date signed 1/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G58673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 W. MADISON ST.
(c) Hospital or institution: 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 W. MADISON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES F. HAAS

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: PETRA E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 19, 1873

8. AGE: Years 74 | Months 0 | Days 12 19 | If less than one day ___ hr. ___ min.

9. Birthplace NEW YORK, N.Y.
(Town, county, and state)

10. Usual Occupation SALESMAN - RETIRED

11. Industry or business —

FATHER
12. Name EDWARD HAAS
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace POTTSTOWN, PA.

16 (a) Informant WIFE
(b) Address 219 W. MADISON ST.

17 (a) CREMATION (b) Date thereof 1/5/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT
Location BALTO. MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address NORTH & PA. AVE., BALTO, MD.

19 JAN 5 - 1948 (b) Lexington-Williams, M.D.
(Date rec'd by registrar)

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1/48 19— at 7 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 NOV 1947 to 1 JAN 1948 and that I last saw h/M alive on 31 DEC 1947

Immediate cause of death: CARCINOMA OF STOMACH — Duration: 2 YEARS?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Milan M.D.

Address 682 WASHINGTON BLVD Date signed 5 JAN '48

G58674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

G58674 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5524 Reisterstown Rd
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 6
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5524 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Uriah Beam

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Margaret E. Beam
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Oct. 23-1864

8. AGE: Years 83 | Months 6 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Pikesville Md
(Town, county, and state)

10. Usual Occupation Harness Maker

11. Industry or business as in 10

MOTHER / FATHER
12. Name George Beam
13. Birthplace Balto Co Md
14. Maiden Name Annie Mitchell
15. Birthplace Balto Co Md

16 (a) Informant Ruler Beam
(b) Address 5524 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6-1948 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. Bergman & Sons
(b) Address Reisterstown, Md

19 (a) Filed Jan 8 1948 (by registrar) (b) Huntington Williams M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1948, at 1:28 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to Jan 4 1948, and that I last saw h~~im~~ alive on Jan 3. 1948.

Immediate cause of death: Hodgkins Disease — Duration: 4 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature C. B. Ensor M. D.
Address 7201 York Rd Date signed 1-4-48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. C58675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1344 Whitecar St
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 Whitecar St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary J. Brooks

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Jos. Brooks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1885

8. AGE Years	Months	Days	If less than one day
62	6	9	hr. min.

9. Birthplace Montgomery Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Abraham Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Nelly Mackel
15. Birthplace Maryland.

16 (a) Informant Joseph Brooks
(b) Address 1344 Whitecar St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director William A. Jackson
(b) Address 846 Penna. Ave.

19 (a) Date received JAN 5 1948 (b) Written by Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1948 at 8 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 48 1947 to Jan 1 1948 and that I last saw h alive on 19

Immediate cause of death Myocarditis — Duration 6 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Kerth M.D.

Address (Date signed)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93-D

Registered No. G58676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Cedardale Road
(c) Hospital or institution: 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Cedardale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucia Maisto

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Ernest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28/1883

8. AGE: Years	Months	Days	If less than one day
64	9	6	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Angelo Vicidomini
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta ?
15. Birthplace Italy

16 (a) Informant Mrs. Marie Greenwald
(b) Address 3404 Cedardale Road

17 (a) Monday (Burial, cremation, or removal) (b) Date thereof 1/5/48 (month) (day) (year)
(c) Cemetery or crematory 3rd Calvary Queens N.Y.
Location Queens, New York

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) JAN 5- 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3- 1948 at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948, to Jan 3 1948 and that I last saw h[illegible] alive on Jan 3 1948.

Immediate cause of death	Duration
Acute Heart Failure	
Due to Chronic Nephritis	
Due to Arteriosclerosis	
Other Conditions ~	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 8 Belvedere [illegible] Date signed 1-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G58677 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Carswell Street
(c) Hospital or institution: 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Carswell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Reynolds Ritter

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Widowed

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1st. 1864

8. AGE: Years	Months	Days	If less than one day
83	10	2	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Dress Maker
11. Industry or business Retired

FATHER
12. Name Alexander E. Kinnear
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ann McCaffery
15. Birthplace Maryland

16 (a) Informant Virginia A. Dasch
(b) Address 1511 Carswell Street

17 (a) Tuesday (Burial, cremation, or removal) (b) Date thereof 1/6/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) JAN 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1948, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 - 1947 to Jan 3 1948, and that I last saw h alive on 19

Immediate cause of death	Duration
Myocardial Degeneration	1yr.
Due to Senile Changes	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A H Thompson M.D.
Address 1710 E 33rd St Date signed 1/7/48

G58678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 B

Registered No. G58678

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 Greenway
(c) Hospital or institution: at Home 12-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Greenway (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Kate Traband Turner

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Quincy E. Turner
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 25 1859
8. AGE: Years 88 | Months 0 | Days 8 | If less than one day: hr. min.
9. Birthplace Upper Marlboro Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name John H. Traband
13. Birthplace Germany

MOTHER
14. Maiden Name Emily C. Trumpkey
15. Birthplace Prince Georges Co.

16 (a) Informant Mrs W. H. Dashiell - (sister)
(b) Address 410 Cedarcroft - (42) —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan - 5 - 48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Stuart Memorial Co.
(b) Address 108 W North Ave

19 (a) JAN 5 - 1948 (Date rec'd by registrar) Wellington Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1948, at 1015 AM.
21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to Jan 2 1948 and that I last saw her alive on Jan 2 1948.

Immediate cause of death: Senility Coma — Duration
Due to Cerebral Hemorrhage ✓
Due to —
Other Conditions ✓
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: ✓
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Allen A. Gastone Lee
Address 1219 Eutaw Place Date signed 1/5/48

VS 150

G58679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G58679 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4325 Wickford Road
(c) Hospital or institution: at Home 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4325 Wickford Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Primrose Koppelman

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Arthur Koppelman
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) June 5 1880

8. AGE: Years	Months	Days	If less than one day
67	6	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name William D. Primrose
13. Birthplace Phila. Penna.

MOTHER
14. Maiden Name Florence Herring
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Arthur Koppelman (husband)
(b) Address 4325 Wickford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Stewart & Mowbray Company
(b) Address 128 W. North Avenue.

19 (a) JAN 5 - 1948 (Date rec'd by registrar) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1948, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Jan 3 1948, and that I last saw h[illegible] alive on Jan 2 1948.

Immediate cause of death: Thrombosis, right middle cerebral artery — Duration 5 days
Due to: Cerebral Arteriosclerosis — 6 yrs.
Due to: Hypertensive cardio-vascular disease — 10 yrs.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry F. Klemfeldt M. D.
Address 1101 St. Paul St. Date signed Jan 3, 48

VS 150

X

G58680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G58680

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3424 Guilford Terrace
(c) Hospital or institution: at home 12-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3424 Guilford Terrace
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Rickert Stoen

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Kemp Stoen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 1868

8. AGE: Years 79 | Months 11 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER — 12. Name Henry Rickert
13. Birthplace Germany

MOTHER — 14. Maiden Name Mary Becker
15. Birthplace Germany

16 (a) Informant Mrs Angelina R Hoinkis daughter
(b) Address 3424 Guilford Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6 48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Stewart Morris Co.
(b) Address 108 Mt Royal Ave

19 JAN 6 1948 (Date rec'd by Registrar) Huntington Williams (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1948, at 6 4. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Jan 4 1948; and that I last saw her alive on Jan 4 1948.

Immediate cause of death	Duration
Carcinoma of Breast	8 yrs
Cerebro vascular Heart disease	3
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence W. Gluck M. D.
Address 3406 St Paul St Date signed 1/5/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G58681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Presstman St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country None

3 (a) FULL NAME Maynard Rogers

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) 1/30/1930
8. AGE: Years 17 | Months 11 | Days 29 | If less than one day: hr. min.
9. Birthplace Baltimore MD (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Frederick Rogers
13. Birthplace md

MOTHER
14. Maiden Name Annie Robinson
15. Birthplace md

16 (a) Informant Frederick Rogers
(b) Address 1210 Pressstman St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location md
18 (a) Funeral director George G. Kelson
(b) Address 1303 Pressstman St
19 (a) JAN 5 - 1948 (Date rec'd by registrar) Written for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2/48 1948, at 1 47 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1947, to 1/2 1948, and that I last saw h.. alive on 1/2 1948.

Immediate cause of death: Lobar Pneumonia
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Signature: Williams M. Garner M.D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Williams M. Garner M.D.
Address 1514 Division St Date signed 1/5/48

VS 180

X

C58682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 83D

Registered No. C58682

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Division Street
(c) Hospital or institution: Provident Hospital 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 W. Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME [redacted], Mary L. LAWS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Damsiel Laws

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/12/85

8. AGE: Years 52 | Months 10 | Days 2 | If less than one day hr. min. 19

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name - Nathal Pynes

13. Birthplace - W. Va

MOTHER 14. Maiden Name Mary Butler

15. Birthplace - Md

16 (a) Informant - Frank Abrams

(b) Address - 2307 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-48 (month) (day) (year)

(c) Cemetery or crematory Laurel Md

Location

18 (a) Funeral director Dorge H. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) JAN 5 - 1948 (Date rec'd by registrar) (b) Funeral Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1947 at 1:28 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1947 to 12/31 1947, and that I last saw her alive on 12/31 1947.

Immediate cause of death Generalized Arteriosclerosis — Duration

Due to Pulmonary Edema and Congestion

Due to Ventral Hernia

Other Conditions Right Hemiplegia of 15 yrs duration (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Gen. Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marcus W. Moore M. D.

Address Provident Hospital Date signed 1/3/47

X

C58683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. C58683

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore #18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Northway (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George K. Seibert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~:

6 (b) Name of husband or wife: Mrs. George K. Seibert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/10/90

8. AGE: Years 57 | Months 7 | Days 23 | If less than one day — hr. — min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Train Dispatcher

11. Industry or business B. & O. R.R.

FATHER
12. Name William Seibert
13. Birthplace West Virginia

MOTHER
14. Maiden Name Delphenia Colbourne
15. Birthplace Mass.

16 (a) Informant Robert C. Seibert
(b) Address 12 16th & King St., Martinsburg W. Va.

17 (a) Cremation (Burial, cremation, ~~or removal~~) (b) Date thereof 1/5/48 (month) (day) (year)
(c) ~~Cemetery or~~ crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Meeks and Son
(b) Address 505 N. Calvert St.

19 (Date rec'd by registrar JAN 5 - 1948) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1948, at 8 13 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1947 to 1/2 1948, and that I last saw her alive on 1/2 1948

Immediate cause of death Arteriosclerotic heart disease with pectoris

Duration

Due to myocardial infarction, recent

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Earle Richardson M.D.
Address Union Memorial Hospital Date signed 1/2/48

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G58684 Registered No.

CM. 109473

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals. 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 Hartford AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh L. Clinton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25 - 1901

8. AGE: Years	Months	Days	If less than one day
46	5	10	hr. min.

9. Birthplace Balto. MD.
(Town, county, and state)

10. Usual Occupation Retired Employee of

11. Industry or business Water Dept. Balto. City

FATHER
12. Name Patrick Clinton
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Elizabeth Wallace
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan. 7 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Eugene O. Conklin & Son
(b) Address 924 S. Eager St.

19 JAN 5 - 1948 (b) Huntington Williams
(Date rec'd by Registrar)

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 - 1948, 5.05 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 27 1947, to Jan. 4 - 1948 and that I last saw him alive on Jan. 4 - 1948

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. T. Benfant

Address Balt. City Hosp. Date signed 1-5-48 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. C58685

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2245 Aisquith Street
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2245 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Faust (Amor Joseph Faust)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elizabeth Parr
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): Jan. 9th., 1871

8. AGE: Years 76 | Months 11 | Days 25 | If less than one day: ######## min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Retired (Teamster

11. Industry or business: Paper Box Mfg.

FATHER
12. Name: Faust
13. Birthplace: Germany

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Mrs. John Schaefer (Daughter)
(b) Address: 2245 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) JAN 5 1948 (Acc'd by registrar) (b) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION 48

20. DATE OF DEATH: Jan. 3rd., 1948, at 7½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1948 to Jan 3 1948 and that I last saw h. alive on Dec 3 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	10 Hrs
Due to Uremia	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: J. R. Thomas M.D.
Address 913 Cathedral St. Date signed Jan 4/48

V S 150

X J. R. Thomas

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1598

Registered No. G58686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916. N. Greenmount Ave
(c) Hospital or institution: 10-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916. N. Greenmount ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Jackson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1882
8. AGE: Years 66 | Months 65 | Days | If less than one day hr. min.
9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace Carolina

MOTHER
14. Maiden Name ?
15. Birthplace South Carolina

16 (a) Informant Mrs. Harriett Jackson
(b) Address 916. N. Greenmount Ave
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan-6-1948 (month) (day) (year)
(c) Cemetery or crematory Sumpter S. C.
Location South Carolina
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave
19 JAN 5 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1948, at M
21. I certify that death occurred on the date above stated; that I attended deceased from November 1947 to Jan. 2 1948, and that I last saw h[illegible] alive on January 2 1948.

Immediate cause of death: Coronary thrombosis

Due to: arteriosclerosis

Due to: Hypertension

Other Conditions: Chronic rheumatism arthritis.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
about
7 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karl Traugott M. D.
Address 623 E. N. Ave Date signed 1/3/49

VS 150

G58687

AB-733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G58687

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 632 S. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Volk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20- 1852

8. AGE: Years 95 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Volk
13. Birthplace Germany

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1948 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Pleasant St.

19 (a) JAN 5 1948 Received by registrar Hattie Williams Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3- 1948, at 10.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11- 1867 xxx to 1-3- 1948, and that I last saw h. alive on 1-3- 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Heart Disease	
Due to Generalized arteriosclerosis	
Other Conditions Cystitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Benford M. D.
Address Balt. City Hosp. Date signed 1-3-48

X

G58688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G58688

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution:
SINAI HOSPITAL. 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3917 Belle Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH SENKER FISHER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband ~~or wife~~ Arthur Fisher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mc. 12, 1877.

8. AGE: Years	Months	Days	If less than one day
70	9	23	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Senker,
13. Birthplace Germany.

MOTHER
14. Maiden Name Mary Sachs,
15 Birthplace Germany.

16 (a) Informant Mr. Jacob Fisher,
(b) Address 3917 Belle Ave.

17 (a) Burial (b) Date thereof 1/7/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Balto. Md.
18 (a) Funeral director David Lemmerman Son
(b) Address 1902 Eutaw Place.
19 (Date received by registrar) JAN 5 - 1948 Keating for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4/1948, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29/47 to 1/4/1948
and that I last saw her alive on 1/4/1948.

Immediate cause of death Cerebrovascular accident — Duration

Due to

Due to

Other Conditions Cardiac decompensation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1/4/48

VS 150

X

G58689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G58689 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 S. Decker Ave.
(c) Hospital or institution: -
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S. Decker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Over

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Theresa Dietmayer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) sept. 26, 1865

8. AGE: Years	Months	Days	If less than one day
82	3	9	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Anthony Over
13. Birthplace not known

MOTHER
14. Maiden Name Margaret Chaney
15. Birthplace Not known

16 (a) Informant Mrs. Gladys Hulseman
(b) Address 806 S. Decker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) JAN 5 1948 (Date rec'd by registrar) Lurington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1948, at 7:00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to Jan 1948, and that I last saw him alive on Jan. 3 19 47

Immediate cause of death Uremia — Duration 1 wk.

Due to Hardening of arteries — 5 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene W. LeDoux

Address 601 N. Ellwood Ave. Date signed M. D. 1/5/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G58690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G58690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1421 Riverside Ave.
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Riverside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura A. Liedlich

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George A. Liedlich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19th. 1870

8. AGE: Years	Months	Days	If less than one day
77	5	12	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry S. Wagner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ellen E. ?????
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Joseph Evans
(b) Address 1421 Riverside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/ 5/ 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Geo. E. Bergen Jr.
(b) Address 1512 Hollins St.

19 (a) JAN 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 1 1948 at 6 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1947 to Jan 1 1948 and that I last saw h[illegible] alive on Dec 30 1947.

Immediate cause of death: Hypostatic Congestion
Due to: Generalized arteriosclerosis

	Duration
	?
	?

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. Ellison.
Address 1421 E. Monument Date signed 1/5/48 M. D.

VS 150

G58691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G58691 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 McCulloh St.
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aquilla Phillips

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Bessie Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1872

8. AGE: Years	Months	Days	If less than one day
75	11	19	hr. min.

9. Birthplace Balto. Md. (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Aquilla Phillips
13. Birthplace Balto Md

MOTHER
14. Maiden Name Priscilla Scott
15. Birthplace Balto Md

16 (a) Informant Franklin Phillips
(b) Address 1902 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 1948 (b) (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1948 19 , at 6. A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Jan 2 1948. and that I last saw h.. alive on Jan 2 1948.

Immediate cause of death

	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius L White M. D.
Address 1802 Penna Ave Date signed 1-5-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G58692 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Lombard St
(c) Hospital or institution:
Univ. Hosp. 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barry Cabell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1947

8. AGE: Years	Months	Days	If less than one day
	7	6	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Cabell
13. Birthplace New Eaton Va.

MOTHER 14. Maiden Name Lillian Artis
15. Birthplace Balto. Md.

16 (a) Informant Robert Cabell
(b) Address 1599 N Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5 48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) 1948 (Date rec'd by registrar) (b) Waiting for Medical Certification

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1948 at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1947 to 1/2 1948, and that I last saw h[illegible] alive on 12/48 1948

Immediate cause of death	Duration
prolonged anes Pneu & Secondary Shock	
Due to	
Due to	
Other Conditions ileo cecal fecal fistula repaired (Include pregnancy within 3 months of death)	
Date of operation 12-22-47	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward E. Hull M. D.
Address Univ. Hosp. Date signed 1/2/48

X

G58693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G58693
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 N. Spring St
(c) Hospital or institution: 10-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town, write RURAL and give town)
(d) Street No. 724 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. B. Scherer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F.
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Charles
6 (c) If alive, give age 83 years
7. Birth date of deceased (mo., day, yr.) Dec. 26th 186

8. AGE: Years	Months	Days	If less than one day
82	-	7	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace U.

MOTHER
14. Maiden Name Francis Gross
15. Birthplace Md.

16 (a) Informant Myrtle Ross
(b) Address 724 N. Spring St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co. Md
18 (a) Funeral director Barnett Francis H. Wright
(b) Address 729 Aisquith St
19 (a) (Date rec'd by registrar) (b) Livingston Williams, Registrar

JAN 5- 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1948, at 11:00 A. M
21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1947, to 1-2 1948, and that I last saw h[illegible] alive on 12-31-1947

Immediate cause of death	Duration
I Congestive Ht. Failure	1 mo.
Due to Hypertension & Gen. Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R W M Daniel
Address 724 N. Spring St Date signed 1-4-48 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G58694 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 Barclay Street
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Barclay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA DORSCH

3 (b) If veteran, name war ---

3 (c) Social Security Account No. -----

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sigmund Dorsch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1862

8. AGE: Years: 86 | Months | Days | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: At home

11. Industry or business

FATHER
12. Name: Joseph Werner
13. Birthplace: Germany

MOTHER
14. Maiden Name: Sophia Schafer
15 Birthplace: Germany

16 (a) Informant: Mrs. Louise Edwardson
(b) Address: 2402 Barclay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: City

18 (a) Funeral director: WIEDEFELD AND SON
(b) Address: GREENMOUNT AVE & 22ND

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2/48 19 , at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20, 1941 to Jan. 2, 1948, and that I last saw h er alive on Jan. 2, 1948

	Duration
Immediate cause of death: Chronic mitral regurgitation	7 years
Due to: Arterio-sclerosis	10 yrs
Due to: Myocardial insufficiency	7 days
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: A. Benedict Bronushas, M. D. M. D.
Address: 3037 O'Donnell St Date signed: JAN 3 - 1948

X

BALTIMORE CITY HEALTH DEPARTMENT

G58695 **CERTIFICATE OF DEATH** 194a Registered No. G58695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3508 Chestnut Ave.
(c) Hospital or institution: 13.6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 Chestnut Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry W. Schneider.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Fannie Schneider
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr) June 5, 1871

8. AGE: Years	Months	Days	If less than one day
76	6	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Penna R.R.

FATHER
12. Name Ferdinand Schneider
13. Birthplace Maryland.

MOTHER
14. Maiden Name Christina Betzner.
15. Birthplace Maryland.

16 (a) Informant Fannie Schneider
(b) Address 3508 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Windsor Mill Road.

18 (a) Funeral director Chisholm & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) (b) Interment Witness

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1948, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1947 to Jan 2 1948, and that I last saw h[illegible] alive on Jan 1 1948

Immediate cause of death Coronary occlusion — Duration 24 hrs.
Due to Arteriosclerosis — 2
Due to Coronary disease.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature [illegible] M. D.
Address 8429 Chestnut Ave. Date signed 1/2/48

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. TYPE OR WRITE PLAINLY, WITH UNFADING INK.

C58696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C58696

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 S. East Ave
(c) Hospital or institution: 7b-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 S East Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Mc=Cleary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or ~~wife~~ Pat Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25-1884

8. AGE: Years 63 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Homefiber

FATHER
12. Name John Fleischman
13. Birthplace Md

MOTHER
14. Maiden Name Laura Bradford
15. Birthplace Boston Mass

16 (a) Informant Nelson Mc=Cleary
(b) Address 417 S. East Ca

17 (a) Burial (b) Date thereof Jan 7 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director John C Moran
(b) Address 3600 Eliatanna St

19 (a) [redacted] (b) Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1947 to 1/4 1948 and that I last saw her alive on 1/3 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertensive Cardio Vascular Renal	
Due to Generalized Arteriosclerosis	
Other Conditions Angina Pectoris	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Arthur J. Lanneville M.D.
Address 333 N. East Ave Date signed 1/5/48

VS 150

G58697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G58697 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ft Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Gough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boleslaus LeBorgn (Hlebowicz)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary LeBorgn (Hlebowicz)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1888

8. AGE: Years	Months	Days	If less than one day
59 60	9	14	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Stanislaus LeBorgn (Hlebowicz)
13. Birthplace Poland

MOTHER
14. Maiden Name Filamina Mlynarczak
15. Birthplace Poland Mlynarczak

16 (a) Informant Mrs. Mary LeBorgn (Hlebowicz)
(b) Address 2203 Gough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County
18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street
19 (a) JAN 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1948, at 11 45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1948, to 1/2 1948, and that I last saw him alive on 1/2 1948
Immediate cause of death Coronary thrombosis — Duration ?
Due to
Due to
Other Conditions Bilateral pneumonia & Influenza — Duration ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Was autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry V. Chase M. D.
Address Mercy Hospital Date signed 1/2/48

G58698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1832 Bank St.
(c) Hospital or institution: - - None - - 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1832 Bank St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - -

3 (a) FULL NAME Margaret L. Friel

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John Friel
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) 12-8-1878

8. AGE: Years	Months	Days	If less than one day
69	0	26	___ hr. ___ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Michael Dunn
13. Birthplace ?

MOTHER
14. Maiden Name Ann ?
15 Birthplace ?

16 (a) Informant John Friel - husband
(b) Address 1832 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) JAN 5 1948 (b) (Filed by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1948, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Jan 1 1948 and that I last saw him alive on Jan 2 1948.

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to Hypertension C.V.D.	years
Due to Bronchitis chr	
Due to	
Other Conditions Anemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James H. Lindsley M.D.
Address 2936 E. Baltimore Date signed 1/5/49.

G58699 G58699

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

Registered No.

TYPE OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Dr. & 31st St.
(c) Hospital or institution: U. S. Marine Hospital 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Ednor Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Ignatius Oliphant ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Div.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1893

8. AGE: Years	Months	Days	If less than one day
54	0	18	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Seafarer

FATHER
12. Name Joseph E. Oliphant
13. Birthplace Md

MOTHER
14. Maiden Name Barbara E. Harlow
15 Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Park
Location Taylor Ave
18 (a) Funeral director Leilly & Zeiler
(b) Address 402 W. Lafayette St

JAN 5 - 1948 (Date rec'd by registrar) (b) Frantz & Williams, Mgrs. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3, 1948 at 2:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1948 to Jan. 3, 1948 and that I last saw him alive on Jan. 3, 1948

Immediate cause of death	Duration
cirrhosis of liver	unk
Due to	
Due to	over
Other Conditions Pneumonia, right lower lobe	1 wk.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature C. H. Dabbs, M. D.
Address Marine Hospital Date signed 1/3/48

VS 150

124 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. 58700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town New Oxford
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Missalthea Diehl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19- 1917

8. AGE: Years 30 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Adams Co Penna (Town, county, and state)

10. Usual Occupation Band Clerk

11. Industry or business

FATHER 12. Name Samuel E. Diehl

13. Birthplace Penna

MOTHER 14. Maiden Name Bessie Chronister

15. Birthplace Penna

16 (a) Informant Wm Fraser F. Director

(b) Address Hanover Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 6th 48 (month) (day) (year)

(c) Cemetery or crematory New Oxford

Location Pennsylvania

18 (a) Funeral director William Cook Inc

(b) Address 1217 S'th Paul St

19 (a) JAN 5 - 1948 (Date rec'd by registrar) (b) Twitmyer Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4-48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-47 19 , to 1-4-47 19 , and that I last saw h[illegible] alive on 1-4-47 19 .

Immediate cause of death	Duration
Respiratory failure	
Due to Intracerebral Pressure	
Due to Rt. frontal tumor	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Hahn M. D.

Address Univ. Hosp. Date signed 1-4-48

VS 150

G58701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G58701

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3487 Childs Court
(c) Hospital or institution: 25-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3487 Childs Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Mary Parlett

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife George B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1892.

8. AGE: Years	Months	Days	If less than one day
55 56	0	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Charlady
11. Industry or business Retired

FATHER
12. Name William H. Colwell
13. Birthplace Penna.

MOTHER
14. Maiden Name Lucinda Gallion
15. Birthplace Baltimore Co. Md.

16 (a) Informant Hazel Parlett
(b) Address 3487 Childs Court

17 (a) Thursday (b) Date thereof I/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) JAN 5 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1948, at 2 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1947, to Jan 4 1948, and that I last saw her alive on Jan 3 1948.

Immediate cause of death	Duration
Pneumonia	2 days
Due to Cancer	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/30/47
Major findings of operation: Generalized Cancer of abdomin, Squamous cell origin
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold H Burns M. D.
Address 529 N. Charles St 1 Date signed Jan 5, 48

X

G58702

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92 B

Registration No. G58702

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Ave
(c) Hospital or institution West Baltimore General 21-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Louise Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Anna M. Tate

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Richard B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 - 1888

8. AGE: Years	Months	Days	If less than one day
59	6	5	hr. min.

9. Birthplace Balto Md (Town, county and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John H. Klein
13. Birthplace Md.

MOTHER
14. Maiden Name Theresa Very
15. Birthplace Md.

16 (a) Informant Mrs. Joseph Klein
(b) Address 707 Chestnut Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Belair Rd

19 (a) JAN 5 - 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1948, at 7 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3 1947 to 1-3 1948, and that I last saw h[illegible] alive on 1-3 1948.

Immediate cause of death Pulmonary Edema — Duration
Due to Rheumatic Heart Disease
Due to Mitral Stenosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Baharky M. D.
Address West Balto Gen'l Hosp Date signed 1-3-48

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINT WITH PENCIL, WITH UNFADING INK.

G58703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G58703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3622 Echodale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry D Peters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Frances J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11-1894

8. AGE: Years 53 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Balto, Md (Town, county and state)

10. Usual Occupation A J Sackett & Son

11. Industry or business

FATHER 12. Name Thomas Peters

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Deman

15. Birthplace Md.

16 (a) Informant Mrs. Frances J. Peters

(b) Address 3622 Echodale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto

18 (a) Funeral director L J Lyck

(b) Address 5305 Harford Rd.

19 (a) JAN 5 1948 (Date rec'd by registrar) Huntington Williams, Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1948, at 8:40 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection, or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William J. Helpick M.D. Medical Examiner.

Date signed Jan 3, 1948

T58704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 58704

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3322 Fleet St.
(c) Hospital or institution: 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) About 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3322 Fleet St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA B. WALDHAUSER

3 (b) If veteran, name war -----

3 (c) Social Security Account No. -----

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Charles Waldhauser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1880

8. AGE: Years 67 | Months 3 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation House-Work

11. Industry or business At Home

FATHER
12. Name George Wolf
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Joseph Wolf (Son)
(b) Address 1834 N. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-48. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd.

18 (a) Funeral director Charles S. Feiler
(b) Address 901 S. Conkling St.

19 (a) JAN 5- 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1948, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1- 48 to Jan 4 1948 and that I last saw her alive on Jan 4 1948

Immediate cause of death Coronary Embolism — Duration 10 min.
Due to Arteriosclerosis — 5 yrs.
Due to Hypertension — 8 yrs.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1710 33rd Date signed 1/5/48

V S 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT WRITE IN SPACE RESERVED FOR BINDING

658705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered 658705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Women's Memorial Hospital 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3537 Newland Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Malcolm Richard Carnes

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1937

8. AGE: Years	Months	Days	If less than one day
10	4	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation School boy
11. Industry or business

FATHER
12. Name Mr. Francis S. Carnes
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Margaretta Goudelock
15. Birthplace South Carolina

16 (a) Informant Mother
(b) Address 3537 Newland Rd.

17 (a) Burial (b) Date thereof 1/7/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICHNER & SONS
(b) Address Balto., Md.

19 (a) JAN 5 1948 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1948, at 3:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1948 to Jan 4 1948, and that I last saw him alive on Jan 4 1948

Immediate cause of death

	Duration
(a) Acute Meningitis, Cerebrospinal	
Due to	
Due to	
Other Conditions None	6 wks

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Katherine Sprunt M. D.
Address Women's Memorial Hosp. Date signed 1-4-48

VS 180

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G58706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2329 Belmont Ave
(c) Hospital or institution: 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Belmont Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME MARY A. WALTMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Frank T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1876

8. AGE: Years	Months	Days	If less than one day
71	4	3	hr. min.

9. Birthplace India (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Jonathan Fay
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Murray
15. Birthplace Scotland

16 (a) Informant Mr. Franklyn Waltman
(b) Address 1608 Walnut St. Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/48 (month) (day) (year)
(c) Cemetery or crematory XXXXXX Loudon Park
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves, Balto., Md.

19 JAN 5- 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1948, at 12:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1947 to 1-4 1948. and that I last saw h[er] alive on 1-4 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	8 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos. Coleman M. D.
Address 120 Eutaw Place Date signed 1-5-48

G58707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 170c

Registered No. G58707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Cold Spring Lane.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME WILLIAM H. ELKINS

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Hilda E. Elkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1906

8. AGE: Years 41 | Months 0 | Days 18 | If less than one day .....hr. .....min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Supt. Aged Home

11. Industry or business Self

FATHER
12. Name Herbert A. Elkins
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary C. Greenlow
15. Birthplace Balto.

16 (a) Informant Mrs. Hilda E. Elkins
(b) Address 2101 W. Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 5 - 1948 (Date rec'd by registrar) Everington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1948, at 7.40 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured pelvis, Laceration of bladder

Due to Fractures, lacerations, and abrasions of both legs.

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 27-15
(a) Date of injury 1-4-48 at 7. p. M.
(b) Where did injury occur? lawn- 2101 W. Cold Spring Lane. Balto., Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian- struck by auto

23. Signature Geo. L. Merrill M.D. Medical Examiner.
Date signed 1-5-48

VS 151

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

C58708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registration No. C58708

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 15-10

(a) Baltimore City, Maryland

(b) Street address Madison St & Linden Ave

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4017 Liberty Heights Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Gertrude Kempel

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife J. William Kempel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1876

8. AGE: Years	Months	Days	If less than one day
71	7	4 6	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Jacob Harbaugh Leber

13. Birthplace York, Pa.

MOTHER

14. Maiden Name Emma Tilyard

15. Birthplace Baltimore

16 (a) Informant Mr. William T. Kempel

(b) Address 2648 Purnell Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JAN 5 - 1948 (Date rec'd by registrar) (b) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5-48 1948 at 12 15 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Dec 1947 to 5 Jan 1948, and that I last saw h[illegible] alive on 2 Jan 1948

Immediate cause of death	Duration
Cardiac failure	5 days
Due to Arteriosclerotic Cardiovascular Disease	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. Allan Cyr M.D.

Address Md. Gen. Hosp. Date signed 1-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G58709

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2584 W. Fayette St.
(c) Hospital or institution: 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2584 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Doering

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Wilhelmina Doering
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1872

8. AGE: Years	Months	Days	If less than one day
75	2	6 7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Baltimore City

FATHER
12. Name William Doering
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Margaret C. Doering
(b) Address 2584 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Frank A. Cole
(b) Address 1[illegible] W. Lombard St

19 (a) JAN 5 Huntington Williams Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2nd 1948, at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1926 to January 1948 and that I last saw h[illegible] alive on Dec. 28 1947

Immediate cause of death	Duration
Acute Dilatation of Heart	2 hrs.
Due to Hypertension arteriosclerotic	
Other Conditions Cerebral Hemorrhage	
disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 116 [illegible] Date signed Jan 4 48

G58710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157c

G58710 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

13-8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 350 N Poole St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Gardini

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/20/47

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Joseph Clyde Gardini
13. Birthplace Crescent Pa.

MOTHER
14. Maiden Name Margaret Schaub
15. Birthplace Balto Md.

16 (a) Informant Margaret Schaub Gardini
(b) Address 350 N Poole St, Balto

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 30 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 5 - 1948 (Date filed by Registrar) (Signature) Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1947, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1947, to Dec 22 1947, and that I last saw h[illegible] alive on Dec 21 1947.

Immediate cause of death	Duration
Cardio-resp failure	
Due to Anencephaly	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. R. Shea, M.D.
Address Univ. Hosp. Date signed 12/29/47

G58711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

G58711 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Loudred & Greenlaw
(c) Hospital or institution: Univ. Hosp. 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Abbott Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy MUMMERT

3 (b) If veteran, name war:

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/47

8. AGE: Years | Months | Days | If less than one day: 1 hr. 30 min.

9. Birthplace: Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Ernst G. Mummert
13. Birthplace: Balto

MOTHER
14. Maiden Name: Mabel Klein
15. Birthplace: Balto

16 (a) Informant: Mabel Mummert
(b) Address: 814 Albert Court

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location: University Medical School DEC 30, 1947

18 (a) Funeral director: Commissioner of Health
(b) Address

19 (a) JAN 5 - 1948 (Date rec'd by registrar) Washington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22/47 19 , at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22/47 19 , to 12/22/47 19 , and that I last saw h[illegible] alive on 12/22/47 19 .

Immediate cause of death	Duration
Cardio-resp failure	
Due to Prematurity (30 weeks)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.

Address Univ Hosp Date signed

VS 150

X

G58712 B.C.H. 97945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registration No. G58712

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave & Dukeland St
(c) Hospital or institution: West Balto. Gen. Hosp. 78-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Ridgewood Ave #15 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Davis

3 (b) If veteran, name war — (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-47

8. AGE: Years	Months	Days	If less than one day
			9 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business —

FATHER
12. Name Irvin Leroy Davis
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Monat
15. Birthplace Balto Md.

16 (a) Informant Mary Davis
(b) Address 4301 Ridgewood Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 30, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 5 - 1948 (Date rec'd by registrar) (Signature) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/47 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29/47 19 to 12/29/47 19 and that I last saw him alive on 12/29/47 19

Immediate cause of death	Duration
Asphyxia	
Due to prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S Waldrop
Address Date signed 12/29/47

VS 150

G58713 B.C.H.9954l

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. G58713

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison and Linden Ave

(c) Hospital or institution: Md. Gen. Hosp. 15.3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1818 Thomas Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Averman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12/27/47

8. AGE: Years | Months | Days | If less than one day 3 hr. min.

9. Birthplace Md. Gen. Hosp. Balto
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Charles Edward Averman

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Elizabeth Violet Brantley

15. Birthplace Baltimore, Md.

16 (a) Informant —

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School DEC 30, 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 5- 1948 (Signature) Geo. Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/47 19 , at 7.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27/47 19 , to 12/27/ 1947, and that I last saw h alive on 12/27 19 47

Immediate cause of death	Duration
Atelectasis	
Due to Newborn	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation autopsy 12/29/47

Major findings of operation:

of autopsy: (Performed)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Thomas C. Webster M. D.

Address Md Gen Hosp Date signed 12/28/47

VS 150

G58714 BCHC 98060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G58714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Green
(c) Hospital or institution: Univ. Hospital 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 534 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy "A" Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	col	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/19/47

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Father Jones
13. Birthplace Lusitania D.C.

MOTHER
14. Maiden Name Ellen Jefferson
15. Birthplace Halifax N.C.

16 (a) Informant Ellen Jones
(b) Address mother

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 30 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 5 1948 (Date rec'd by Registrar) (b) Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1947 at 7 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1947 to 12/23 1947 and that I last saw h[illegible] alive on 12/23 1947.

Immediate cause of death	Duration
Respiratory obstruction	
Due to Aspiration	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Univ Hosp Date signed 12/24/47 M. D.

X

G58715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G58715

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 Barclay street
(c) Hospital or institution: 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 E. Preston street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HONORA FINNERAN

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: Edward Finneran
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1856

8. AGE: Years	Months	Days	If less than one day
91	5	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name James Hanly
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Finneran
15. Birthplace Ireland

16 (a) Informant Mr. James Finneran
(b) Address 1113 Barclay street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 6/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Chas. L. Evans, Son & Inc
(b) Address 11 E. W. M. Royal Ark

19 (a) JAN 5 - 1948 (Date rec'd by registrar) (b) Lavington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1948, at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Dec 1947 to 3 Jan 1948 and that I last saw h[er] alive on 3 Jan 1948

Immediate cause of death: suppurative peritonitis
Duration 6 hrs
Due to: diffuse respiratory infection
Duration 5 hrs
Due to: arteriosclerotic heart disease
Duration ?
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Samuel Silverfield M. D.
Address 714 E. Preston Date signed 5 Jan 48

VS 150

C58716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. C58716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Walker Ave
(c) Hospital or institution: St Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Kerby Dr 7 (If rural give location)
(e) Citizen of foreign country? VD (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM SREBNIK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife EDITH R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1889

8. AGE: Years	Months	Days	If less than one day
58	4	21	hr. min.

9. Birthplace NY (town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name unknown
13. Birthplace New York

MOTHER
14. Maiden Name Esther
15. Birthplace New York

16 (a) Informant Edith Srebnick
(b) Address 2991 Aver New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-48 (month) (day) (year)
(c) Cemetery or crematory
Location New York N.Y.

18 (a) Funeral director Baker Lewis Inc
(b) Address 2400 Eutaw Place

JAN 6 1948 (Date received by registrar) Clayton Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1948 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1947 to 1/5 1948 and that I last saw h[illegible] alive on 1/5 1948

Immediate cause of death Cardiac failure
Diabetic mellitus
Decubitus

Due to	Duration
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Stagnes Date signed 1/5/48

X

58717.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ 658717 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland Aves
(c) Hospital or institution West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Rodgers

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-18-3420

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife late Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1888

8. AGE: Years 59 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Stock Clerk Book Dept

FATHER
12. Name Wolf Rodgers
13. Birthplace Poland

MOTHER
14. Maiden Name Dora Koenig
15. Birthplace Poland

16 (a) Informant Charles Miller
(b) Address 2536 Cold Spring Lane

17 (a) Burial (b) Date thereof 1 8 48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mickve-Kodesh Cem.
Location Baseline Lane

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North Ave.

19 (a) JAN 6 - 1948 (b) Hutchins for Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1948, at 3:00 P.M.

21. I ~~certify~~ that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Pulaski M.D.
Medical Examiner.
Date signed 1/5/48

VS 191

G58718

B.C # 95603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G58718

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: 137
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Hanlon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1947

8. AGE: Years	Months	Days	If less than one day
	1	—	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William M Cohen
13. Birthplace New York City

MOTHER
14. Maiden Name Beatrice Silberman
15. Birthplace Balto, Md

16 (a) Informant William M Cohen
(b) Address 3009 Hanlon Ave

17 (a) Burial (b) Date thereof Jan 6, 1948
(Burial, cremation, or removal) (mo., day, yr.)
(c) Cemetery or crematory Workmen Circle Cem
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 JAN 6 1948 Huntington for Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1948 at 12:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1948 to 1/5 1948, and that I last saw h.. alive on 1/5 1948.

Immediate cause of death ASPIRATION PNEUMONIA — Duration 1 hr.

Due to

Due to

Other Conditions PREMATURITY — 1 month

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Susman M.D.
Address Sinai Hospital Date signed 1/5/48

G58719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G58719

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3906 Northern Parkway
(c) Hospital or institution: 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 Northern Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME S. ELIZABETH LAUPP

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Henry C. Laupp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7th, 1862

8. AGE: Years 85 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Arnold
13. Birthplace Unknown

MOTHER
14. Maiden Name Heubiar
15. Birthplace Unknown

16 (a) Informant Mrs. Regina Walsche
(b) Address 4611 Marble Hall Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/7/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Rd.

JAN 6 - 1948 (Date rec'd by Registrar) (b) Courtesy for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4th, 1948 at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1st 1947 to Jan 4 1948 and that I last saw him alive on Jan 3 1948

Immediate cause of death: myocardial degeneration — Duration: 4 day

Due to: Hypostatic congestion — 1 month

Due to: Arterio sclerosis — 10 yrs

Other Conditions: Adeno-Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place) —
(e) Means of injury

23. Signature Edward Jenson M. D.
Address 1 W. Overlea Date signed 1/6/48

VS 150

058720 Dr Lycaught N.B.H. Green

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 67706

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 162
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1142 Strieker St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Johnson

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/47

8. AGE: Years	Months	Days	If less than one day
		1	26 hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Otis Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Bertha Ferguson
15. Birthplace North Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Loc Johns Hopkins Medical School DEC 29 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 6 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1947, at 3 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1947 to Dec 26 1947, and that I last saw her alive on Dec 26 1947.

Immediate cause of death	Duration
Prematurity	1 Day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. N. Lycaught M. D.
Address Johns Hopkins Date signed 12-27-47

VS 150

X

G58721 BC 2-9702 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. G58721

CERTIFICATE OF DEATH 158

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution: The Johns Hopkins Hospital 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 E. Eager Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Ledmun (438966)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 1 hr. 0 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Edgar Ledmun
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Collins
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 JAN 6 1948 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1947, at 12:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1947 to Dec. 22 1947, and that I last saw him alive on Dec. 22 1947.

Immediate cause of death	Duration
Achondroplastic dwarf	
Due to Hydramnios	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B C Williams M. D.
Address The Johns Hopkins Hospital Date signed 12-22-47

Johns Hopkins Medical School DEC 23 1947
Commissioner of Health

B C Williams, M.D. Registrar

G587722

AB- 89752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G587722

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1374 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William Abrams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March ? 1887

8. AGE: Years 60 (8)60 | Months 10 | Days | If less than one day ....hr. ....min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Abrams (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Bell (D
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn.
Location

18 (a) Funeral director George F. Klein
(b) Address 1307 Pennsylvania Ave

19 (a) JAN 6 1948 (Date rec'd by Registrar) (b) Filed at Baltimore, Md. Registrar

V S 150

MEDICAL CERTIFICATION

PM

20. DATE OF DEATH Jan. 1- 1948 at 10-05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1944 to 1-1- 1948 and that I last saw him alive on 1-1- 1948

Immediate cause of death	Duration
Bronchopneumonia	2 wks
Due to	
Due to Cerebral Accident, Hemiplegia	- 4 yrs
Other Conditions Hypertension Heart Failure	- yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr M. D.
Address Balt City Hosp Date signed 1/5/48

83a

G58723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G58723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2124 Division St
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 Division St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Mahoney

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Lillian Mahoney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1901

8. AGE: Years	Months	Days	If less than one day
46	4	11	hr. min.

9. Birthplace Wash D.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Gladys Ransome
(b) Address 2124 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George D. Nelson
(b) Address 1303 Presstman St

19 JAN 6 1948 (Date rec'd by registrar) Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1948, at 2:33 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1947 to 1/2 1948 and that I last saw h— alive on 1/2 1948

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burk Shutts M. D.
Address 2139 D St Date signed 1-2-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58724 B.C. #8502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G58724

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 W. Franklin Street.
(c) Hospital or institution: 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 635 W. Franklin Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth P. Faber

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1947

8. AGE: Years	Months	Days	If less than one day
	3	16	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Edward White
13. Birthplace —

MOTHER
14. Maiden Name Teretha Hobbs
15. Birthplace N. C.

16 (a) Informant Teretha Fobbs
(b) Address 635 W. Franklin St

17 (a) Burial (b) Date thereof 1-6-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location and

18 (a) Funeral director George E. Nelson
(b) Address 1303 Pressman St

19 (a) JAN 6 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3, 1948, at 6.45p M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 4 Jan 48

G58725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G58725
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4001 N. CHARLES ST.
(c) Hospital or institution: 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN ELLIOTT DUKER
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. WIDOWED
6 (b) Name of husband or wife HENRY P. DUKER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 29, 1866

8. AGE: Years 81 | Months 8 | Days 6 5 | If less than one day ....hr. ....min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name CHARLES W STOW
13. Birthplace BALTIMORE MD.

MOTHER
14. Maiden Name MARGARET JANE COLLINS
15. Birthplace DEL.

16 (a) Informant J. CARROLL STOW
(b) Address 4001 N. CHARLES ST.

17 (a) BURIAL (b) Date thereof JAN 6 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE MD

18 (a) Funeral director HENRY W. JENKINS SONS CO.
(b) Address MC CULLOH & ORCHARD ST.

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4th 1948, at 1 03 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1947 to January 4 1948 and that I last saw h[illegible] alive on January 4 1948.

Immediate cause of death: Coronary Occlusion - Duration 2 days
Due to Coronary Artery Disease - 10 years
Due to Generalized Arteriosclerosis - 10 years
Due to
Other Conditions: HERPES ZOSTER 8 months
CHRONIC KIDNEY INSUFFICIENCY
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Lon Brinkoff
Address Funeral Director Date signed Jan 5 1948

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered G58726

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3112 Woodhome ave
(c) Hospital or institution: 21.5
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Woodhome ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. David G. Moore

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margret D. Moore
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
59 ✓			hr. min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Margaret D. Moore
(b) Address 3112 Woodhome Ave.

17 (a) Burial (b) Date thereof Jan 7/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1200 Eutaw Place

19 JAN 6 1948 (Date received by local registrar) (d) Institution for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1947, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946, to Dec. 29 1947, and that I last saw h. im alive on Dec. 29 1947.

Immediate cause of death	Duration 1½ hr.
Pulmonary edema	
Due to Myocardial failure	2 yrs
Due to Hypertension Arteriosclerosis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robt B. Wright M. D.
Address Medical Arts Bldg. Date signed 1/29/48

VS 150

G58727.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G58727

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3112 - Woodbine Ave
(c) Hospital or institution: 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Woodbine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret D. Moore

3 (b) If veteran, name war: C
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife David G. Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George J. Dickerson
13. Birthplace U. S.

MOTHER
14. Maiden Name Margaret E.
15. Birthplace U. S.

16 (a) Informant Mary M. Perley Mother
(b) Address 34 Highfield Ave Homerville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 7/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director John O. Butterfield & Son
(b) Address 1200 Eutaw Place

19 (a) JAN 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1947 at 12 35 P.M.

21. I certify that I took charge of the remains described above, held an exam. & Insp. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions Despondency.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/31 at 7 P.M.
(b) Where did injury occur? 3112 - Woodbine Ave Balto Md
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating gas

23. Signature Thomas J. Mackell M.D. Medical Examiner.
Date signed 12/31/47

VS 151

G58728

CERTIFICATE CORRECTED 5-24-40 ✓

CERTIFICATE OF DEATH 937

G58728 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Dec 15-13
(b) Street address
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ellis Applebaum

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-9976

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Theresa Tillie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Not known

13. Birthplace Russia

MOTHER 14. Maiden Name Not known

15. Birthplace Russia

16 (a) Informant Edw. Appleblatt

(b) Address 4206 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-40 (month) (day) (year)

(c) Cemetery or crematory Pikesdale

Location

18 (a) Funeral director Jack Levine Inc.

(b) Address 2100-02 Eutaw Place

19 (a) JAN 6 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4 1940 at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.

Date signed 1/4/40

VS 151

X

G58729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

G58729 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Violet Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Elaine Pollakoff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Merwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20, 1921

8. AGE: Years 26 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Catonsville Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Morris Leskin
13. Birthplace Russia

MOTHER 14. Maiden Name Yetta
15. Birthplace Russia

16 (a) Informant Merwin Pollakoff
(b) Address 2905 Violet Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-48 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Herzug Lem

18 (a) Funeral director Jack Lemle Inc
(b) Address 2600 Eastern Place

19 (a) JAN 6 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 JAN 1948, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1 JAN 1948 to 5 JAN 1948 and that I last saw her alive on 5 JAN 1948

Immediate cause of death	Duration
Coma	
Due to Uremia	
Due to polycystic kidneys	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: polycystic kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide~~, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irving Schultz M. D.
Address Sinai Hospital Date signed 5/14/48

X

658730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658730

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 Poplar Grove St.
(c) Hospital or institution: 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Day

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Late Julia T. Day
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1875.

8. AGE: Years	Months	Days	If less than one day
72	7	0	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired Car Repairman
11. Industry or business Baltimore Transit

FATHER
12. Name Nicholas Day
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Julia McGarry
(b) Address 416 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry H. Kirtzie
(b) Address 4101 Edmondson Ave.

19 (a) JAN 6 - 1948 (Date rec'd by Registrar) (b) Huntington Ave. Baltimore Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3/48 19 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to Jan 3 1948 and that I last saw him alive on Jan 3 1948.

Immediate cause of death Congestive Heart Failure + Insufficiency
Arteria sclerosis typ. heart dis.
Due to Coronary thrombosis + Congestive failure
Due to Arterio sclerosis
Other Conditions Chronic Pancreatic inflammation
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration
Several Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. Nickel M. D.
Address 4101 Edmondson Ave Date signed

VS 180

937

658731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658731

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 S. Streeper
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 S. Streeper
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zelka Iwaniec

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12 1867

8. AGE: Years	Months	Days	If less than one day
85	3	22	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs Beliga
(b) Address 1015 S. Streeper

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7/48 (Month) (Day) (Year)
(c) Cemetery or crematory St. Stanislaus
Location Highland Town

18 (a) Funeral director Marie E. Fialkowska
(b) Address 1530 S. Kenwood ave

19 (a) Jan 6 1948 (Date rec'd by registrar) (b) Thurston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 JAN. 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Oct. 1947 to 4 JAN 1948
and that I last saw her alive on 31 DEC. 1947

Immediate cause of death CEREBRAL THROMBOSIS — Duration 2 HRS

Due to ARTERIOSCLEROSIS GEN. — 20 YRS.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Lightstein M. D.
Address 121 S. HIGHLAND AVE Date signed 4 JAN 48

VS 130

G58732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

G58732 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5416 Wasena ave.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5416 Wasena ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country.

3 (a) FULL NAME Mr. John Zelbron

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-1485

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Julia Zelbron
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) 10/20/05

8. AGE: Years	Months	Days	If less than one day
42	2	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Tool Sharpener
11. Industry or business

FATHER
12. Name Blades Zelbron
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Kopec
15. Birthplace Poland

16 (a) Informant Julia Zelbron
(b) Address 5416 Wasena Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. Co.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 JAN 6-1948 (Date rec'd by registrar) Registrar for Williams Dist.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1948, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 6 1947, to Jan. 4 1948, and that I last saw h/m alive on Jan. 4 1948.

Immediate cause of death	Duration
Perforated gastric Ulcer.	
Due to Partial exhaustion,	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul D. Brennan M. D.
Address Bon Secours Hosp. Date signed 1/4/1948

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G58733 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26-8
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Mt. Pleasant Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: DORA KRAMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1878

8. AGE: Years 69 | Months 10 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife.

11. Industry or business

FATHER
12. Name: Christian Redmers
13. Birthplace: Germany

MOTHER
14. Maiden Name: Dont know
15. Birthplace: Germany

16 (a) Informant: Mrs. Irene Younger
(b) Address: 122 S. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/48 (month) (day) (year)
(c) Cemetery or crematory Woodland
Location Balto Co Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St

19 (a) JAN 6 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3, 1948 at 7.15 P M

21. I certify that I took charge of the remains described above, held an autopsy- Franklin Square Hosp. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulmonary embolism

Due to: Thrombosis of deep femoral vein (left)

Other Conditions: Autopsy performed at Franklin Square Hosp failed to notify the Chief Med. Exam. office. Above cause of death made out by the Hospital Physician- Dr. Jos. B. Schrock (Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 19/4

(a) Date of injury 12-13-47 7 P. M.
(b) Where did injury occur? Mount & Pratt St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian-struck by auto

23. Signature: Howard J. Mueller M.D. Medical Examiner.
Date signed 1-9-48

VS 181

658734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

Registered No. 658734

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 7.3
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dov
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 631 N. Duncan St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Filliaup

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16 1886

8. AGE: Years	Months	Days	If less than one day
61	1	18	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Harry Filliaup
13. Birthplace Md

MOTHER
14. Maiden Name Maggie Bauers
15. Birthplace Md

16 (a) Informant Frank Filliaup
(b) Address 3237 Clifmont Ave

17 (a) Burial (b) Date thereof Jan 8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Uelund Funeral Home
(b) Address 2008 Orleans St

19 (a) JAN 6 1948 (b)
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4, 1948, at 1 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Inhaling gas
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-4-48 at appox. 11 A. M.
(b) Where did injury occur? 631 N. Duncan St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work) NO
(d) Means of injury Inhalation of illuminating gas

23. Signature A. P. Tulinski M.D.
Medical Examiner.
Date signed 1-5-48

G58735

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 94a

Registered No. G58735

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PENNSYLVANIA (b) County
(c) City or town NEW PARK (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ELLIS WEBB McELWAIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MARY PAULINE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/24/95

8. AGE: Years	Months	Days	If less than one day
52	8	12	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation INSURANCE AGENT
11. Industry or business INSURANCE

FATHER
12. Name JOHN McELWAIN
13. Birthplace YORK COUNTY, PENNA.

MOTHER
14. Maiden Name EDITH BROOKS
15. Birthplace YORK COUNTY, PENNA.

16 (a) Informant MRS. Webb McElwain
(b) Address New Park, Penna.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 9 48 (month) (day) (year)
(c) Cemetery or crematory Centre
Location New Park Penna.

18 (a) Funeral director W Howard Webb
(b) Address Fawn Grove, Penna.

19 (a) Filed (Registrar) (b) Registered by (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6/48 at 4 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1948 to 1/6 1948 and that I last saw him alive on 1/6 1948

Immediate cause of death CARDIAC FAILURE — Duration
Due to CORONARY THROMBOSIS
Due to ARTERIOSCLEROSIS
Other Conditions HYPERTENSION, ESSENTIAL
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Houseka M.D.
Address St. Jos. Hospital Date signed 1/6/48

VS 150

G58736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G58736
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3916 Cold Spring Lane
(c) Hospital or institution: 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3916 Cold Spring La ne
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country --

3 (a) FULL NAME J. HOWARD PEREGOY

3 (b) If veteran, name war	3 (c) Social Security Account No.
No.	Yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of husband or wife Anna L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1867

8. AGE: Years	Months	Days	If less than one day
80	1	2	..... hr. ..... min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual Occupation Retired Insurance Agent
11. Industry or business Baltimore Life

FATHER
12. Name Joseph Peregoy
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Sarah J. Weisner
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mrs. Margaret Peregoy
(b) Address 3916 Cold Spring La ne

17 (a) Burial (b) Date thereof 1/7/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towsen, Md. (Balto. Co.)

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves., Balto, Md.

19 (a) JAN 6 1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1948, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1947 to Jan 5 1948, and that I last saw h... alive on Jan 5th 1948.

Immediate cause of death	(a)	Myocardial	6 days
Due to	(b)		
Due to	(c)	General Debility, Anemia	
Other Conditions	(d)		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: No
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H Evans M. D.
Address 612 N Eutaw St Date signed

G58737.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G58737.
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 N. Patterson Pk. Ave.
(c) Hospital or institution: 8.2
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 N. Patterson Pk. Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country -- -

3 (a) FULL NAME JOHN HENRY DILL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Eleanor I. Dill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1870

8. AGE: Years	Months	Days	If less than one day
77	8	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business --

FATHER
12. Name William Dill
13. Birthplace Germany

MOTHER
14. Maiden Name Elizebeth Lutz
15. Birthplace Germany

16 (a) Informant Mrs. Anna Myers-- Daughter
(b) Address 1919 N. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves. Balto., Md.

19 (a) JAN 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3, 1948, at 2.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 15 1947, to January 3 1948, and that I last saw h[illegible] alive on Jan 2 1948.

Immediate cause of death	Duration
Cardiac Decompensation	1 Day
Due to Acute Insufficiency	2 Days
Due to	
Other Conditions Influenza and Acute Bronchitis (Include pregnancy within 3 months of death)	13 Days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Eisenberg M. D.
Address 7025 North Ave Date signed 1-5-48

X

G58738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G58738 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave 27-15
(c) Hospital or institution: Methodist Ho me For The Agad
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7/28/47
(e) Length of stay in Baltimore (yrs., mos., or days) 82Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME ROBERT RION JOHNSON

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Nettie May Coleman
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr): May 28, 1865

8. AGE: Years 82 | Months 7 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Bookkeeper
11. Industry or business: Retired

FATHER
12. Name: Gersham D. Johnson
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Catherine McCahan
15 Birthplace: Frederick, Md.

16 (a) Informant: Mamie B. Fisher
(b) Address: 2211 W. Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~: Loudon Park Cem.
Location: Ba ltimore Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC
(b) Address: North & Pa. Aves., Balto, Md.

19 JAN 6 - 1948 (Date rec'd by Registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3, 1948 19xx, at 2:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 1 1947 to JAN 3 1948 and that I last saw h/M alive on JAN 1 1948

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to Arteriosclerosis	20 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J. Davies M. D.
Address 800 N 32nd St Date signed 1-5-48

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G58739

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5104 CORDELIA AVE
(c) Hospital or institution: 27-18
ABOVE ADDRESS
(d) Length of stay in ~~hospital or inst.~~ (yrs., mos., or days) 5 YRS
(e) Length of stay in Baltimore (yrs., mos., or days) 5 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE, MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5104 CORDELIA AVE
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME JANE H. FASTIE

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NO

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 17, 1857

8. AGE: Years 90 | Months 9 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace YORK, PA.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name HENRI FASTIE
13. Birthplace FRANCE

MOTHER
14. Maiden Name CATHERINE CLOCKSON
15. Birthplace GERMANY

16 (a) Informant Miss IDA F. FASTIE
(b) Address 5104 CORDELIA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/7/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE, MD

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address NORTH & PA AVES. BALTO, MD

19 (a) JAN 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4/48 19— , at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Jan 4 1948, and that I last saw her alive on Jan 4 1948.

Immediate cause of death: Myocarditis Arterio-Sclerosis — Duration: Gradual

Due to: —

Due to: —

Other Conditions: —
(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Brady M. D.
Address 1403 Park Ave Date signed 1-5-48

VS 150

X

658740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered No. 658740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5223 Linden Heights Ave
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5223 Linden Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mollie L. Wheat

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Samuel T. Wheat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1 1859

8. AGE: Years	Months	Days	If less than one day
88	9	3	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name William Urry
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. George M. Holmes
(b) Address 5223 Linden Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7 1948 (month) (day) (year)
(c) Cemetery or crematory St. Pauls
Location Rock Hall Md

18 (a) Funeral director Harry W. Simmons
(b) Address 4204 Ridgewood Ave

19 (a) JAN 6 1948 (Must not be filled in by registrar) (b) Huntingtown Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 4 - 1948, at 6.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-10-1947 to Jan-4-1948 and that I last saw h[illegible] alive on Jan-2-1948

Immediate cause of death: Myocardial insufficiency (Pulmonary) — Duration: 10 D.
Due to: Chron. Arteriosclerosis — 5 yrs.
Due to: Old Hypertension
Other Conditions: Acute Cystitis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm. T. Geyer Sr.
Address 156 W. Madison Ave Date signed 1/6/48 M. D.

X

G58741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58741

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 738. N. Linwood Ave
(c) Hospital or institution: 7-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 738 N. Linwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Mary Kolb.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed.

6 (b) Name of husband or wife Louis Kolb.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23r 1872

8. AGE: Years	Months	Days	If less than one day
75		12	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Francis X. Purzer.
13. Birthplace Baltimore. Md.

MOTHER
14. Maiden Name Mary Graff.
15. Birthplace Baltimore Md.

16 (a) Informant Miss Marie J. Kolb.
(b) Address 738. N. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7th. 19 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road.

18 (a) Funeral director Geo. M. Fink. & Son.
(b) Address 811. N. Wolfe. St.

19 JAN 6 - 1948 (Date rec'd by registrar) Clinton Williams M.D. (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4th. 19 48 at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 19 47 to Jan. 4 19 48, and that I last saw h- alive on Jan 4 19 48

Immediate cause of death Cerebral Apoplexy — Duration 10 days

Due to

Due to Hypertensive Cardio-vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm J Schmitz M. D.
Address 701 N. Kenwood Ave. Date signed 1/7/48

G58742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 467

Registered No. G58742

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 438 Whitridge Avenue
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) about 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 Whitridge Ave.
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Florence V. Potts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Robert E. Potts
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1883

8. AGE: Years	Months	Days	If less than one day
64	4	35	--hr. --min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ------

FATHER — 12. Name	------- Kueberth
FATHER — 13. Birthplace	------
MOTHER — 14. Maiden Name	------ Boch
MOTHER — 15. Birthplace	------

16 (a) Informant Philip F. Potts
(b) Address 438 Whitridge Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

1948 JAN 6 (Date Rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1948, at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to Jan 5 1948, and that I last saw h alive on Jan 4 1948

Immediate cause of death

Coronary occlusion — Duration 4 hrs.

Due to Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 14, 1947

Major findings of operation: By Tissue Section Coronary occlusion

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert H. Kueberth Jr. M. D.
Address 2706 St Paul St Date signed 1/5/48

VS 150

G58743

424231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 B

Registered No. G58743

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot
(c) City or town Trappe (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Doris V. Fehsenfeld
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Luther Fehsenfeld
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 10-10-98

8. AGE: Years	Months	Days	If less than one day
49 50	2	26	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER 12. Name ~~Thomas~~ Rudolph C. Thomas
FATHER 13. Birthplace Md.
MOTHER 14. Maiden Name Marion V. Poole
MOTHER 15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Baltimore Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 705 N. Calvert St.

JAN 6 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1948, at 2 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26- 1947 to 1-5- 1948 and that I last saw her alive on 1-5- 1948.

Immediate cause of death: Respiratory Failure
Due to: Hodgkins Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: None

Duration
8 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 1-5-48

058744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 058744

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7/12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 McCabe Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rutherford (MARY STREET RUTHERFORD)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Walter O.

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1892

8. AGE: Years 55 | Months 1 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Harford C. Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name James P. Street
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Sara E. stokes
15. Birthplace Harford Co., Md.

16 (a) Informant Walter O. Stokes
(b) Address 624 McAbee Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 JAN 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1948, at 9:45 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1948 to 1-4 1948, and that I last saw her alive on 1-4 1948

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E B Hearn M. D.
Address Univ. Hosp Date signed 1-4-48

VS 180

X

G58745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G58745
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave 8-6
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Scheidt (MARY ELIZABETH SCHEID)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Charles Scheidt

6 (c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Nov. 5, 1879

8. AGE: Years: 69 | Months: 2 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George Miller
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Mr. Charles Scheidt
(b) Address: 1507 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 JAN 6 1948 (Date rec'd by Registrar) (Christington Williams M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Jan 1948, at 10:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Dec 1947 to 4 Jan 1948, and that I last saw h[illegible] alive on 4 Jan 1948

	Duration
Immediate cause of death: Terminal Bronchopneumonia	4 days
Due to: Cerebral Hemorrhage	4 days
Due to: Hypertensive Cardio-vascular disease	10 yrs
Other Conditions: Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: A. Allan Spies M. D.
Address: Md. Gen. Hosp. Date signed: 4 Jan 48

VS 150

937

G58746

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

137a

Registered No. G58746

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL 8-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Sinclair Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE KORTE (GEORGE HENRY KORTE)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-18-4387

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie E. Korte

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) June 1, 1867

8. AGE: Years 80 | Months 7 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Sinai Hospital

FATHER
12. Name William Korte
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Annie E. Korte
(b) Address 2117 Sinclair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/48 (month) (day) (year)
(c) Cemetery or crematory St. Johns Lutheran Cem.
Location Howard County

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 JAN 6, 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 4 1948, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC. 21 1947 to JAN. 4 1948, and that I last saw h/M alive on JAN. 4 1948

	Duration
Immediate cause of death: RESPIRATORY FAILURE	
Due to: BRONCHOPNEUMONIA	48 hrs.
Due to: POST-OPERATIVE	
Other Conditions: PROSTATIC HYPERTROPHY	

(Include pregnancy within 3 months of death)
Date of operation JAN. 2, 1948
Major findings of operation: PROSTATIC HYPERTROPHY
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Lerman M. D.
Address Sinai Hospital Date signed JAN. 4, 1948

VS 150

G58747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registration No. G58747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Dillon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mary Kacala

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-09-6694

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or ~~wife~~ Mr. John Kacala

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24 1877

8. AGE: Years	Months	Days	If less than one day
70	0	11/12	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mr. Adam Golen

13. Birthplace Poland

MOTHER 14. Maiden Name Madeline Pawlus

15. Birthplace Poland

16 (a) Informant Son-in-law

(b) Address 2407 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-48 (month) (day) (year)

(c) Cemetery ~~cemetery~~ ST. STANISLAUS

Location BALTIMORE MD

18 (a) Funeral director George A. Weber

(b) Address 705 S. Conkling St

19 (a) JAN 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 1948 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Jan 5 1948, and that I last saw h alive on Jan 5 1948

Immediate cause of death	Duration
Coronary occlusion, cerebral hemorrhage, pulmonary edema	2 days
Due to Hypertensive Cardio-Vascular disease	15 yrs
Due to	
Other Conditions Arteriosclerosis, General	15 yrs

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Bachrach M. D.

Address Church Home & Hosp. Date signed 1/5/48

VS 150

X

G58748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 746F

G58748 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 N. Curley
(c) Hospital or institution: 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Curley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If so, name country

3 (a) FULL NAME Rose Frasca

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Enrico Frasca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6 1901

8. AGE: Years	Months	Days	If less than one day
46	1	28 27	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Luigi Siddi
13. Birthplace Italy

MOTHER
14. Maiden Name Maria ?
15. Birthplace Italy

16 (a) Informant Enrico Frasca (Husband)
(b) Address 107 N. Curley St.

17 (a) Burial (b) Date thereof Jan. 7/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Holy Redeemer Cem.
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Curley St.

19 (a) JAN 6 - 1948 (b) Huntington Wolfe, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1948, at 7:40a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Jan 1948, and that I last saw alive on Jan 2 1948

Immediate cause of death	Duration
Pneumonia	
Due to Metastatic Carcinoma	
Primary lesion gall bladder	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation October, 1947
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles B. MacMunn M. D.
Address 2911 E. Baltimore St Date signed Jan 8 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 52a

Registered No. G58749

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 75 days
(e) Length of stay in Baltimore (yrs., mos., or days): 75 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: DC (b) County:
(c) City or town: Washington, NE
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 727 Kerney St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Wallace Theodore Forsman

3 (b) If veteran, name war: WW 2
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 11, 1912

8. AGE: Years	Months	Days	If less than one day
35	7	24	hr. min.

9. Birthplace: Duluth, Minn. (Town, county, and state)
10. Usual Occupation: Engineer
11. Industry or business: Seafarer

FATHER
12. Name: Jacob Forsman
13. Birthplace: Finland

MOTHER
14. Maiden Name: Marie ?
15. Birthplace: Finland

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 7-48 (month) (day) (year)
(c) Cemetery or crematory: Arlington National
Location: Arlington Va.

18 (a) Funeral director: Ellsworth Armacost
(b) Address: 3911 Liberty Heights Ave

19 (a) JAN 6 1948 (Date rec'd by registrar) Waiting for Affidavit

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 4 1948, at 7:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1947, to Jan. 4 1948, and that I last saw him alive on Jan. 4 1948.

	Duration
Immediate cause of death: Carcinoma right kidney with massive metastases liver; metastases to lung and	UNKNOWN
Due to: ascending colon	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J. van Ackeren, Medical Director
Address: Medical Offber in Charge Signed 1/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58750 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 S. FRANKLINTOWN RD
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 S FRANKLINTOWN RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY A McKAY.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 21 1864

8. AGE: Years	Months	Days	If less than one day
83	0	15,4	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name THOS. McKAY.
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARY LEVI
15. Birthplace IRELAND

16 (a) Informant MARY C McKAY.
(b) Address 130 S FRANKLINTOWN RD.

17 (a) BURIAL. (Burial, cremation, or removal) (b) Date thereof JAN-8-48 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL CEM
Location OLD FREDERICK RD

18 (a) Funeral director Bernard C Hanlon
(b) Address 121 E Wood St

19 JAN 6 1948 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4th 1948, at 11.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1947, to Jan 4 1948, and that I last saw him alive on Jan 3 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 4 Days

Due to

Due to

Other Conditions: Arteriosclerosis - S.V.D. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Schapiro M. D.
Address 1501 Annapolis Date signed X 1/5/47

G58751 Smith Williams Esh-K

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G58751 Registered No. 150684

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT FOLD FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Jefferson St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-26-90

8. AGE: Years 57 | Months 3 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Charles Jolley
13. Birthplace Md

MOTHER 14. Maiden Name Anna Smith
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Md

18 (a) Funeral director A Prut Williams
(b) Address 1515 McElderry St

JAN 6 1948 (Date received) (Registrar) Hunting to Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2- 1948, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5 1947 to 1-2 1948 and that I last saw him alive on 1-2 1948.

Immediate cause of death	Duration
Myocardial Infarction (Fresh)	
Due to Arteriosclerosis	
Due to Hypertension (Essential)	
Other Conditions Old Myocardial Infarction (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman M. Millinkoff M. D.
Address Johns Hopkins Hosp Date signed 1/9/1948

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

058752 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Jackson

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Married

6 (b) Name of husband or wife Ernest Jackson
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr) Mar. 12, 1905

8. AGE: Years	Months	Days	If less than one day
42	9	24	____hr. ____min.

9. Birthplace Petersburg, Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Kaiser
13. Birthplace Petersburg, Va.

MOTHER
14. Maiden Name Gertrude Moore
15. Birthplace Petersburg, Va.

16 (a) Informant: Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9-1948 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto. Md.

18 (a) Funeral director Henry O. Wilson
(b) Address 1010 Belvedere Ave

19 (a) JAN 6 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1948, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1947 to Jan. 5 1948 and that I last saw her alive on Jan. 5 1948.

	Duration
Immediate cause of death 1- Pelvic abscess with localized peritonitis	Unknown
Due to 2-Cardiovascular renal disease	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Van Ackeren, Medical Director M.D.
Address Medical Officer in Charge Date signed 1/5/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

658753 C.F. 116330 — Registered No. 658753

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2Hrs15 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1070 W. Fairmount AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Charles Oliver Reynolds

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25 - 1911

8. AGE: Years 36 | Months 10 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Othella Reynolds
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Smith
15. Birthplace MD.

16 (a) Informant Records B.C.H.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem'
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) JAN 6 1948 (Date received by registrar) (b) Lennington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 5 - 48 1948, 4.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1- 5 - 1948 to 1-5-48 1948, and that I last saw him alive on 1-5- 1948

Immediate cause of death: Uraemia; Hypert. C-V disease — Duration
Due to: Subacute Glomerulonephritis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: the above
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William M. Straight M. D.
Address B.C.H. Date signed

X

G58754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

G58754 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 N. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Audrey Duckett Fleet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23, 1926

8. AGE: Years 21 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Merman Duckett
13. Birthplace Mongomery Co. Md.

MOTHER
14. Maiden Name Ethel
15. Birthplace Mongomery Co. Md.

16 (a) Informant Ethel Fleet
(b) Address 905 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 6 - 1948 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5, 1948, at 8.30 a M

21. I certify that I took charge of the remains described above, held an Inspection and Ex thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic heart disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

25. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/5/48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

C58755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. C58755

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 N. Gilmore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L. Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26 1900

8. AGE: Years: 47 | Months: 10 | Days: 8 | If less than one day: hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER 12. Name Henry Fisher
13. Birthplace Md.

MOTHER 14. Maiden Name Linie ?
15. Birthplace Md.

16 (a) Informant Bertha Fisher
(b) Address 402 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem.
Location

18 (a) Funeral director Mr. Katz R. Williams
(b) Address 322 N. Schroeder St.

19 (a) [illegible] (b) Thurlington Williams

JAN 6 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 1948, at 7 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947 to Jan. 7 1948 and that I last saw h[illegible] alive on Jan. 7 1948.

Immediate cause of death: Coronary Occlusion Heart Failure — Duration: 3 wks

Due to: Arteriosclerosis

Due to: Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 1/6/48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

The 658756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 658756

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32 E Calvert St.
(c) Hospital or institution: Union Memorial Hospital 9-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1665 Shady Side Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Berman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Mrs. Michael Berman
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) October 2, 1886

8. AGE: Years	Months	Days	If less than one day
61	3	3	hr. min.

9. Birthplace Sweden (Town, county, and state)
10. Usual Occupation not employed
11. Industry or business

FATHER
12. Name Michael Berman
13. Birthplace Sweden

MOTHER
14. Maiden Name Emma Rockoff
15. Birthplace Sweden

16 (a) Informant wife
(b) Address 1665 Shady Side Road, Balto 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 JAN 6 1948 (Date Rec'd by Registrar) Arlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1948, at 5:42 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1947, to Jan. 5 1948. and that I last saw him alive on Jan. 5 1948.

Immediate cause of death Respiratory failure	Duration
Due to Bronchopneumonia	
Due to Carcinomatosis of Brain	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation January 2, 1948
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Clarke
Address Univ. Memorial Hosp. Date signed 1-6-48

X

VS 150

G58757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58757

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2508 Southern Ave
(c) Hospital or institution: 27-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C. Schroeder

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Frederick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1867

8. AGE: Years	Months	Days	If less than one day
81	80	-	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business None.

FATHER
12. Name William Mates
13. Birthplace Ireland

MOTHER
14. Maiden Name Agnes Redman
15. Birthplace Ireland

16 (a) Informant Mrs. Agnes Russell
(b) Address 2508 Southern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

19 (a) JAN 6 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1948, at 10 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Jan 4 1948, and that I last saw h[illegible] alive on Dec 23 1947.

Immediate cause of death	Duration
Acute Coronary Occlusion	1 day
Due to Arteriosclerotic Heart Disease	5 years.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Brown Dunlap M.D.
Address 4808 Bryant St. Date signed 1/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

White

058758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. 058758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hospital
(c) Hospital or institution: Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 740 W. Fayette St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Forest Webb

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 16, 1903

8. AGE: Years: 44 | Months: 1 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business:

FATHER
12. Name: George Webb
13. Birthplace: Kentucky

MOTHER
14. Maiden Name: Anna Sizer
15. Birthplace: Virginia

16 (a) Informant: Annie Webb
(b) Address: 740 W. Fayette Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: Jan. 6-48 (month) (day) (year)
(c) Cemetery or crematory: -
Location: Hopewell, Virginia

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) Jan 6 1948 (Date rec'd by Registrar) Clayton Williams (Clerk) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-5 1948, at 6.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1948 to 1-5 1948, and that I last saw him alive on 1-5 1948

Immediate cause of death	Interval between onset and death
Asphyxiation Pneumonia	
Due to Coma	
Due to Intestinal obstruction due to incarcerated hernia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: R. L. Jamison M. D.
Address: Univ. Hosp. Balto. Date signed 1-5-48

G58759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G58759

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Q. A.
(c) City or town Glenburnie, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. S.E.Cor. Drum Point Road & first Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mabel Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife J. Fred Johnson

6 (c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) April 9, (1886) 1886

8. AGE: Years 61 (63) | Months 8 | Days 26 | If less than one day 15 hr. min.

9. Birthplace Lake Shore, A.A.County, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Jubb
13. Birthplace Anne Arundel County, Md.

MOTHER
14. Maiden Name Josephine Linstead
15. Birthplace Anne Arundel County, Md.

16 (a) Informant Wilmer M. Johnson
(b) Address Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7, 48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Baltimore 25, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) JAN 6 1948 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1947 to 1/4 1948 and that I last saw h[er] alive on 1/4 1948

Immediate cause of death: (a) Coronary Failure; (b) Arteriosclerosis — Duration

Due to (a) —

Due to

Other Conditions Terminal Resp Failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R.A. Neuhauser, M.D.

Address Univ. Hosp. Date signed 1/6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58760 B. S-96735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

C58760 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Maynadier Ave
(c) Hospital or institution: W. of Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baley Berg Reed I

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	(S)

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 47

8. AGE: Years	Months	Days	If less than one day
		20	hr. min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Randolph J. Reed
13. Birthplace Balto, Md

MOTHER 14. Maiden Name Mary E Reed Wright
15. Birthplace Balto, Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School DEC 29 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 6 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 20 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10, 1947, to Dec 20 1947, and that I last saw the living on Dec 20, 1947.

Immediate cause of death	Duration
Resp. Failure	
Due to Prematurity	
Due to Weight 2 lb 11	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address W. B. G. H. Date signed Dec 20 '47

VS 130

G58761 HEALTH DEPARTMENT—CITY OF BALTIMORE G58761

B.C.-B-97937

CERTIFICATE OF DEATH 161a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

If U. S. Veteran specify WAR

2. FULL NAME High

(a) Residence: No. 4805 Walther Blvd St., 27 Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) 20 Dec 47

7. AGE Years	Months	Days	If LESS than 1 day hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME Arnold Marion Fiske

14. BIRTHPLACE (city or town) (State or country) Farmisboro Pa

MOTHER

15. MAIDEN NAME Clara Linda Osborne

16. BIRTHPLACE (city or town) (State or country) Arnold Penna

17. INFORMANT Brother

(Address) 4805 Walther Blvd 14

18. BURIAL, CREMATION, OR REMOVAL Johns Hopkins Medical School DEC 23 1947

19. UNDERTAKER Commissioner of Health

(Address)

20. JAN 6 1948 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. 20, 1947

22. I HEREBY CERTIFY, That I attended deceased from 20 Dec 47 to 20 Dec 47

I last saw h alive on 20 Dec 47 Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Erysipelas Coccal — Duration Birth

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. Holland M. D.

(Address) Hosp

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58762

BC. C98150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G58762 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital 19.4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 12hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore - 23.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 S Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Tippett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name George Martin Tippett
13. Birthplace [illegible] Md.

MOTHER
14. Maiden Name Della Marie Bowers
15. Birthplace Carroll Co., Md

16 (a) Informant Mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School DEC 29, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 6 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/47 19 , at 3:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1947 to 12/26 1947, and that I last saw him alive on 12/26 1947

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harlan H. Bintzer M. D.
Address Franklin Square Hosp. Date signed 12/26/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58763 BC #97531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G58763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. Carolina St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Spence "a"

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-27-47

8. AGE: Years | Months | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Paul Spence

13. Birthplace Va

MOTHER 14. Maiden Name Dora Spence

15. Birthplace N.C.

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School DEC 30 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 6 1948 (Date rec'd by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1947, at 6 A.M. 30

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1947 to Dec 29 1947 and that I last saw h[illegible] alive on Dec 29 1947.

Immediate cause of death prematurity — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address Johns Hopkins Hosp. Date signed 12-29-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58764 B.C. 4-92511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1160a

Registered No. G58764

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Lorraine

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1741 McKean Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Curry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-21-47

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation: Child

11. Industry or business

FATHER
12. Name: Benjamin Curry
13. Birthplace: Md

MOTHER
14. Maiden Name: Geraldine Meads
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical School DEC 23 1947

18 (a) Funeral director: Commissioner of Health
(b) Address

19 (a) JAN 6 1948 (Date rec'd by registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 19 47, at 10 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 19 47 to Dec 22 19 47 and that I last saw h.r.s alive on Dec 22 19 47.

Immediate cause of death	Duration
Intracranial Hemorrhage	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Johns Hopkins Hosp. Date signed 12-23-47

G58765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58765 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Hayward Ave
(c) Hospital or institution: ---
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town 3907 Hayward Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ba ltimore, Md.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME LAURA BELLE FROMM

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John William
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 31, 1868

8. AGE: Years	Months	Days	If less than one day
79	0	4 5	.....hr. .....min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John Henry Keller
13. Birthplace Maryland

MOTHER
14. Maiden Name Corilla Zimmerman
15 Birthplace Maryland

16 (a) Informant Mr. Walbert Fromm
(b) Address 3907 Hayward Ave., Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/48 (month) (day) (year)
(c) Cemetery or crematory XXXX Stone Chapel
Location Baltimore Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves, Balto., Md.

19 JAN 6 1948 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5, 1948 XX at 11:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31- 1947 to Jan 5 1948
and that I last saw h[illegible] alive on Jan 5 1948

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Myocarditis	
Due to Arterio Sclerosis	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E E Nelson M. D.
Address Pikesville, Md. Date signed 1-6-48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146B

Registered No. 058766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2618 Boone St
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Boone St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Duncan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Ethel Duncan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1913

8. AGE: Years	Months	Days	If less than one day
34	1	21	hr. min.

9. Birthplace Wholeyaville, Maryland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Peter E. Duncan
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Timmons
15. Birthplace Maryland

16 (a) Informant Ethel Duncan
(b) Address 2618 Boone St.

17 (a) Burial (b) Date thereof 1 7 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wholeyaville
Location Maryland

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

JAN 6 1948 (Date rec'd by registrar) (Signature of registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947 to Jan 4 1948, and that I last saw h[illegible] alive on Dec 4 1948.

Immediate cause of death Carcinoma & Pregnancy — Duration 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis A. Johnson M. D.
Address 2329 Guilford Ave Date signed Jan 6 1948

058767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

Registered No. 058767

Type or print clearly in black ink. Do not abbreviate. If unknown, write unknown. If the deceased was a child or a woman, state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: Dorsey F. Lambert L. Balto. Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Federal
(c) City or town RFD 3
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Albert J. Zimmerman

3 (b) If veteran, name war —— 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ruth Zimmerman
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1909

8. AGE: Years	Months	Days	If less than one day
38	10	13	____ hr. ____ min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)
10. Usual Occupation ~~Machinist~~
11. Industry or business Dairy Farmer

FATHER
12. Name Marshall L. Zimmerman
13. Birthplace Frederick Co.

MOTHER
14. Maiden Name Emma V. Eastburg
15. Birthplace Frederick Co.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Luth. Cem.
Location Frederick Md.

18 (a) Funeral director M. R. Atkinson & Son
(b) Address Frederick Md.

19 JAN 6 1948 (Date rec'd by registrar) (c) Arlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6- 19 48 at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 19 48 to 1-6 19 48, and that I last saw h.. alive on 1-5 19 48.

Immediate cause of death: Paranchymal cerebral hemorrhage
Due to: Fracture of skull

Duration

Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward E. Hall M. D.
Address Univ. Hospital Date signed 1-6-48

VS 150

58768 Birth Certificate 1948-00673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 058768

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 8-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 N. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy (Broadmoor) Bredariol

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1948

8. AGE: Years | Months | Days: 1 | If less than one day: 6 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Angelo (Broadmoor) Bredariol
13. Birthplace Baltimore

MOTHER 14. Maiden Name Esther (Baby) (Boy Broadmoor) Nuether
15. Birthplace Baltimore Bredariol

16 (a) Informant Esther (Baby) (Boy Broadmoor)
(b) Address 1123 N. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Lally & Zaiser Inc.
(b) Address 403 S. Wolfe St.

19 (a) 1-7-1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1948 to Jan 6 1948, and that I last saw h/s alive on Jan 6 1948.

Immediate cause of death: Cardio Respiratory Failure — Duration
Due to: Prematurity
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Williams M. D.
Address Mercy Date signed 1-6-48

Correct age is extremely important

X

8769 BC- C 43706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 115C

G58769 Registered No.

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address Moniment & Rutland Ave
(c) Hospital or institution: Sinai Hosp. 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lois Sue Leiberman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1946

8. AGE: Years	Months	Days	If less than one day
1	10	9	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles Leiberman
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Florence Levin
15 Birthplace Baltimore Md

16 (a) Informant Charles Levin
(b) Address 1619 Limden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan6, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bpwleys Lane
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave
19 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

correct age is impossible to ascertain

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1948, at 2:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30/1947 to 1/6/1948, and that I last saw h[illegible] alive on 1/6/1948

Immediate cause of death: Acute resp. failure — Duration
Due to: Congenital Hrt. Disease
Due to:
Other Conditions: Tonsillectomy
(Include pregnancy within 3 months of death)
Date of operation 1/2/48
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Ennis
Address Sinai Hosp Date signed 1/6/48 M. D.

J. Ennis

58770 Sawyer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 58770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6004 Burgess Avenue
(c) Hospital or institution: 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6004 Burgess Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Katie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1855

8. AGE: Years	Months	Days	If less than one day
92	6	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Benjamin H. Parker
(b) Address 6004 Burgess Avenue

17 (a) Burial (b) Date thereof 1-9-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 JAN 7 1948 (Date rec'd by Registrar) Hamilton Fort Williams, M.D. Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1948, at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to June 6 1948 and that I last saw h/M alive on June 6 1948.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to Arteriosclerotic Heart Disease	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Sawyer M.D.
Address 4803 Harford Date signed 1/7/48

Please write the causes of death clearly and legibly. Physician: please write the correct age in especially important.

Ed. X

58771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 37B

Registered No. G58771

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4003 Chatham Road.
(c) Hospital or institution: 15.10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4003- Chatham Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yvonne Fischer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1932

8. AGE: Years	Months	Days	If less than one day
16			hr. min.

9. Birthplace Savannah Ga
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Mortimer Fischer
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Leah Werner
15. Birthplace Balto Md

16 (a) Informant Mortimer Fischer
(b) Address 4003 Chatham Road

17 (a) Burial (b) Date thereof 1-8-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mishkan Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1400 Eutaw Place

19 JAN 7 1948 Clayton Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1948, at 7.30 A M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic encephalitis

Due to Parkinsonism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dr. John R. Davis per Howard Lundvig, M.D.
Medical Examiner.
Date signed 1-6-48

correct age is especially important. Abbreviations: please write out the cause of death clearly and legibly.

VS 191

G58772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No. G58772

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 W HAMBURG ST.
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 W HAMBURG ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY C ~~GRIEVES~~ GRIEVES

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-05-3873

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB-4-1900

8. AGE: Years	Months	Days	If less than one day
47	11	2	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation SHEET METAL WORKER
11. Industry or business STANDARD GAS + EQUIPMENT

FATHER
12. Name JOSHUA. ~~GRIEVES~~ GRIEVES
13. Birthplace MARYLAND

MOTHER
14. Maiden Name LENA. RICKTER
15. Birthplace GERMANY

16 (a) Informant MRS MARGT RYAN
(b) Address 704 W HAMBURG ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN-9-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK.
Location FREDERICK AVE

18 (a) Funeral director Bernard C Hunter
(b) Address 121 E West St

19 JAN 7 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 6th 1948, at 12 M A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 1st 1947, to Jan 6 1948, and that I last saw him alive on 1-6-48 19

Immediate cause of death	Duration
Bilateral Pulmonary tuberculosis & exhaustion	1yr
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Lampe M.D.
Address 642 N Eutaw Date signed 1-6-48

G58773

BALTIMORE CITY HEALTH DEPARTMENT ✓ X G58773

BC-48-00204 CERTIFICATE OF DEATH 160a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bal' Hosp for Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 21 (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 N. Stuart St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Griffin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1948

8. AGE:

Years	Months	Days	If less than one day
0	0	0	4 hr. 4 min.

9. Birthplace Balto. #21 (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Roland James Griffin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Matilda Dora Campbell
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Matilda D. Campbell
(b) Address Balto-28, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/48 (month) (day) (year)
(c) Cemetery or crematory Woodland
Location Taylor Ave.

18 (a) Funeral director Thos. J. Connelly
(b) Address 418 Eastern Ave.

19 (a) 1-7-1948 (Date rec'd by Registrar) (b) Huntington Williams (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1948, at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1948, to 1-6 1948, and that I last saw him alive on 1-6 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 4 hrs 4 min

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Edgar Purnell M. D.

Address 101 E. Biddle Date signed 1-6-48

X

C58774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 136

C58774
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 N.Parrish St.
(c) Hospital or institution: 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 N.Parrish St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: SYLVIA MILES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1927

8. AGE: Years 20 | Months 10 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Alcomock, Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Milford Miles
13. Birthplace Virginia

MOTHER
14. Maiden Name Esther Laster
15. Birthplace North Carolina

16 (a) Informant Addie Savage
(b) Address 1149 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh St.

19 (a) JAN 7 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1947, at 1.30a M

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12-31-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58775 BN. 116135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G58775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 McCullough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2nd. 1860

8. AGE: Years	Months	Days	If less than one day
87	10	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Carroll Sr.
13. Birthplace ?

MOTHER
14. Maiden Name Josephine Lomack
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof Jan. 8, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balty. National
Location Md

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (Registered by registrar) Jan 7 1948 Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1st. 1948 at 12.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26/ 1947 to Jan. 1st 1948, and that I last saw him alive on Jan. 1st 1948

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive Cardiovascular disease	
Due to Arteriolarnephrosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac enlargement

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Bunford M. D.
Address Balt City Hosp Date signed 1-2-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G58776 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3815 St. Margaret St.
(c) Hospital or institution: 25-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3815 St. Margaret St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Charles Gastinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of ~~husband or~~ wife: Anna Gastinger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 11 1881

8. AGE: Years 66 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Janitor

11. Industry or business

FATHER
12. Name: Charles Gastringer
13. Birthplace: Balto.

MOTHER
14. Maiden Name: ?
15. Birthplace: Balto

16 (a) Informant: Anna Green
(b) Address: 2225 Lamsey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 8 48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: 4300 Belair Rd

18 (a) Funeral director: The Riggel Bros.
(b) Address: 213 [illegible]

19 JAN 7 1948 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 1948, at 10 AM

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Lobar pneumonia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: [signature] M.D. (Medical Examiner)
Date signed January 5, 1949

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

Registered 15542

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Brooklyn 25 (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Keyser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James S. Keyser (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1908

8. AGE: Years 39 | Months 0 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Bodkins Creek, Anne Arundel County Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Thomas P. Rafter
13. Birthplace Baltimore

MOTHER
14. Maiden Name Martina Barnes
15. Birthplace Baltimore

16 (a) Informant James S. Keyser
(b) Address Brooklyn 25

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie Md.

18 (a) Funeral director Geo. F. Beyer Jr.
(b) Address 1512 Hollins St.

19 JAN 7 1948 (Date rec'd by Local Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5, 1948, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4, 1948 to Jan 5, 1948 and that I last saw ~~K.R.~~ alive on Jan 5, 1948

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Pulmonary Edema	?
Bronco-pneumonia?	
Due to: Acute Hemmorrhagic Nephritis	?
Other Conditions: Acute Hemmorrhagic Gastritis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Acute hemmorrhagic nephritis, acute hemmorrhagic gastritis

of autopsy: Pulmonary edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James S. Gianella M.D.

Address St Josephs Date signed 1/5/48

V S 150

G58778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G58778

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charlotte O Higgs

3 (b) If veteran, name war W | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1877

8. AGE: Years 70 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Sidney O'Ho

13. Birthplace Md

MOTHER 14. Maiden Name Margaret Tulane

15. Birthplace Md

16 (a) Informant Mrs Harry Gambrill

(b) Address 4102 E 36th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/48 (month) (day) (year)

(c) Cemetery or crematory Baltimore Md

Location Baltimore Md

18 (a) Funeral director Wilson & Hoge

(b) Address 1211 Park Ave

19 (a) Date rec'd by Registrar (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1948 at 12 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1947 to Jan 6 1948, and that I last saw h alive on Jan 3 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 1 Month

Due to Cerebral arteriosclerosis — 5 yrs.

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A L Charlton M.D.

Address 6710 York Rd Date signed Jan 8 1948

G58779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G58779 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10-1
(c) Hospital or institution: West Baltimore GEN Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Crocker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stefano Pecora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20. 1873

8. AGE: Years 74 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Gardener

11. Industry or business

FATHER
12. Name Frank Falzoni
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa (Unknown)
15. Birthplace Italy

16 (a) Informant Marina Pecora

(b) Address 353 East St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/10/48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Baltimore Md

18 (a) Funeral director Nelson Gordon Dye

(b) Address 1214 E Pratt St

19 (a) JAN 9 1948 (Month, day, year) (b) Registrar Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1948 at 6:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1948, to Jan 6 1948, and that I last saw h. C. alive on Jan 6 1948.

Immediate cause of death Pulmonary Edema — Duration

Due to Cardiac Decompensation

Due to Arteriosclerotic Heart Disease

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C. Natelyo M.D.

Address W.B.G.H. Date signed 6 Jan 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G58780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2644- Frederick Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gerald William CHARLES H. ZEITERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	213-26-5688

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11. 1929

8. AGE: Years	Months	Days	If less than one day
18	5	6	hr. min.

9. Birthplace Baltimore MD
(Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business

FATHER
12. Name Alfred Zeiters
13. Birthplace Baltimore, MD

MOTHER
14. Maiden Name Martha Koeffin
15. Birthplace Baltimore MD

16 (a) Informant Edith Elliott
(b) Address 1109 Northington Blvd

17 (a) Burial (b) Date thereof 1/9/48
(Burial, cremation, or removal) (month) (day) (year)

(a) Cemetery or crematory Mt. Auburn
Location Baltimore MD

18 (a) Funeral director Wilhelm & Son
(b) Address 1217 E. Fayette St.

19 JAN 7 - 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5, 1948, at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions Fracture of Skull

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 12-24-47 2014 5:40 P. M.
(b) Where did injury occur? outside 2336- Frederick Avenue Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by auto

23. Signature Earl L. Kaylor M.D.
Medical Examiner.
Date signed 1-6-48

VS 191

G58781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G58781
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27. N. CAREY ST.
(c) Hospital or institution: 264
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 SIXTH ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EVA DAHLE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife AUGUST DAHLE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 18, 1868

8. AGE: Years	Months	Days	If less than one day
79	5	19	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation
11. Industry or business HOUSEWIFE

FATHER
12. Name JOHN GAST
13. Birthplace GERMANY

MOTHER
14. Maiden Name AMELIA LUX
15 Birthplace GERMANY

16 (a) Informant WALTER J. DAHLE
(b) Address 3124 NORTHERN PKWY

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/10/48 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 (a) JAN 7 1948 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1948, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 29 1947 to January 6 1948, and that I last saw h[illegible] alive on January 6 1948

Immediate cause of death	Duration
Cardiac Neer	
Due to Hemiplegia	
Due to	
Other Conditions Senile (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 27 N. Carey Date signed 1/6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

658782 AC - F 58782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

115c

✓ 658782 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 15-7
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (~~yrs.~~ or days) 1
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Popular Grove
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lowes Hyder

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife ~~Mary Hyder~~ none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1943

8. AGE: Years	Months	Days	If less than one day
4	1	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James R. Hyder
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Thelma M. Schmidt
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Hyder
(b) Address 2211 Popular Grove St.

17 (a) Burial (b) Date thereof 1/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] 1948 (b) [illegible] Williams, M.D.
(Filed by registrar)

V9-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12/48, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22/48 to 6/12/48, and that I last saw h/m alive on 6/12/48

Immediate cause of death	Duration
Respiratory failure - due to cerebellar tumor	
Due to Possible Glioma Thyroid Degeneration	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Williams M. D.
Address Church Home & Hospital Date signed 6 June 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G58783

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Spring Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Frank Svoboda) ROSE SVOBODA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65 smt			hr. min.

9. Birthplace Kolin Czechoslovakia
(Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name Frank Svoboda
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Elizabeth Unknown
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Rosa Kozak
(b) Address 100 [illegible] Parkway E.

17 (a) Burial (b) Date thereof 1/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location Baltimore Md.

18 (a) Funeral director Wilson & Son
(b) Address 219 E. Pratt St.

19 JAN 7 1948 (b) Huntington Williams M.E.
(Date rec'd by Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3, 1948 at 9.05p M

21. I certify that I took charge of the remains described above, held an [illegible] thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull -
intra cranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 3/1
(a) Date of injury 1-3-48 at 8.30 pM
(b) Where did injury occur? Eden St. (Balto. & Lombard
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Earl L. Kruger M.D.
Medical Examiner.
Date signed 4 Jan 48

X

G58784 JL - 116348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 M

G58784 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 2-7-46
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4618 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Morstein

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Late Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1870

8. AGE: Years	Months	Days	If less than one day
78 77 ?			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Isaac Morstein
13. Birthplace ? Russia

MOTHER
14. Maiden Name ?
15. Birthplace ? Russia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan. 8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men's Comm.
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 JAN 7 - 1948 Huntington Williams M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Jan. 6 19 48 at 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 19 48 to Jan. 6 19 48 and that I last saw h[im] alive on Jan. 6 19 48

Immediate cause of death	Duration
Probable gastro intestinal neoplasm	P
Due to Peripheral vascular collapse	P
Due to above	
Other Conditions Cachexia, dehydration	P

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 1-6-48

X

G58785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G58785
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 E University Parkway
(c) Hospital or institution: 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 318 E University Parkway
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Wallace Buck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race N. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Wm R. Buck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/12/1862

8. AGE: Years 85 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Home Maker

11. Industry or business

FATHER 12. Name Michael Wallace
13. Birthplace Va

MOTHER 14. Maiden Name Susan Wayland
15. Birthplace Va

16 (a) Informant Mrs. R. Buck
(b) Address 318 E University Parkway

17 (a) Burial (b) Date thereof 1/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Front Royal Va
Location Front Royal Va

18 (a) Funeral director J. Fahey Sons
(b) Address 1208 Eutaw St.

19 JAN 7 - 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Jan 6 1948 and that I last saw her alive on Jan 6 1948

Immediate cause of death	Duration
Myocardial Arterio-sclerosis	Granted ✓
Due to Hypertension	—
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H H Hoody M. D.
Address 1403 Park Ave Date signed 1-7-48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58786

BALTIMORE CITY HEALTH DEPARTMENT ✓ G58786 Registered No.

CERTIFICATE OF DEATH 1318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Normal Avenue
(c) Hospital or institution: 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 Normal Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel J. Anderson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clara C. Etzel
6 (c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Dec. 19th., 1874

8. AGE: Years	Months	Days	If less than one day
73	0	18	~~hours~~ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Merchant-marine
11. Industry or business: Banana Supply Co.

FATHER
12. Name: Daniel Anderson
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Mrs. Clara Anderson -Wife
(b) Address: 1614 Normal Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Herford Avenue

19 (a) (Date received) (b) (Registrar) Williams MD Registrar

JAN

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6th., 1948, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 6 1948 and that I last saw h[illegible] alive on Jan 5 1948

Immediate cause of death	Duration
Cardio Vascular disease	2 yrs
Due to —	
Due to —	
Other Conditions Cystitis	1 yr

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Frank X Kruger M. D.
Address: 700 Harlem Rd Date signed

X JAN 6 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58787

SC 1 V# 10113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G58787
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 25 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1332 S Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Kelly.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-4-48

8. AGE: Years	Months	Days	If less than one day
—	—	1	25 hrs. ... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Kelly, Joseph.
13. Birthplace Balto

MOTHER
14. Maiden Name Fid, Katherine.
15. Birthplace Balto.

16 (a) Informant Same
(b) Address

17 (a) Burial (b) Date thereof 1/7/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location O'Donnell St extended

18 (a) Funeral director J.O. Krause & Son
(b) Address 1216 S. Charles St

19 (a) 1948 (b) Huntington Nelli...
(Date rec'd by registrar)

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6- 1948, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1948 to 1-6 1948, and that I last saw her alive on 1-5 1948

Immediate cause of death Resp. & Cardiac Failure — Duration —

Due to Prematurity. — Duration 25 hrs

Due to — Duration —

Other Conditions — Duration —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Fellsperger M.D.
M. D.
Address Mercy Hosp Date signed 1-6-48

G58788

BC: C 8710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104a

G58788 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 WARREN AVE
(c) Hospital or institution: 221
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 WARREN AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NATHAN ROBERT LAMOREAUX JR.

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 26, 1947

8. AGE: Years	Months	Days	If less than one day
	4	11	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name NATHAN R. LAMOREAUX
13. Birthplace PENN.

MOTHER
14. Maiden Name ELIZABETH H. KEARNEY
15. Birthplace BALTIMORE, MD

16 (a) Informant NATHAN R. LAMOREAUX FATHER
(b) Address 122 WARREN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/8/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ LORRAINE
Location WOODLAWN, MD

18 (a) Funeral director FRED A. KRAUSE & SON
(b) Address 1211 S. CHARLES ST

19 (a) Rec'd by (Registrar) Registrar

JAN 9 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1948 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1948 to Jan. 6, 1948, and that I last saw him alive on Jan. 2, 1948.

Immediate cause of death: Uppper Respiratory Infection — Duration

Due to

Due to

Other Conditions Mild Rickets, Mild Hydrocephalus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Friedman, M.D.

Address 1319 Eutaw St. Date signed 1/6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58789 BALTIMORE CITY HEALTH DEPARTMENT G58789
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3509 Southern Ave
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 Southern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Kasal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1876

8. AGE: Years 71 | Months | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Mail Carrier

11. Industry or business Retired

FATHER 12. Name Joseph Kasal

13. Birthplace Bohemia

MOTHER 14. Maiden Name Frances Klama

15. Birthplace Bohemia

16 (a) Informant Mary Kasal

(b) Address 3509 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balt Md

18 (a) Funeral director Mayhew Brockbank

(b) Address 900 N. Chester St

19 (a) 1948 (Date filed by registrar) (b) Hattie Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1948, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Jan 6 1948, and that I last saw him alive on Jan 6 1948.

	Duration
Immediate cause of death: Coronary Thrombosis	1/4/48
Due to: Chr Myocarditis	Jan 1944
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J Ryan M.D.

Address 901 N Eutaw St Date signed 1/7/48

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58790 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G58790

CERTIFICATE OF DEATH

108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 ALLENDALE ST
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 ALLENDALE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE M GREEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife Late ELIZABETH (MICHAELS) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 10, 1867

8. AGE: Years	Months	Days	If less than one day
80	7	25	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation RETIRED FOREMAN
11. Industry or business BALTO. CITY STREET CLEANING

FATHER
12. Name FRANK GREEN
13. Birthplace MD.

MOTHER
14. Maiden Name JENNIE LEHMAN
15. Birthplace MD.

16 (a) Informant MRS MARIE SHUE
(b) Address 724 ALLENDALE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 8, 1948 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location WOODLAWN, MD.

18 (a) Funeral director Henry N Wetzler
(b) Address 401 Edmondson Ave

19 (a) 1948 (Date rec'd by registrar) Hattie Lee Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 5 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Jan 5 1948 and that I last saw him alive on Jan 4 1948.

Immediate cause of death: Lobar pneumonia — Duration: 2 days
Due to: Cerebral hemorrhage
Due to:
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest H. Rabe
Address 1730 Pleasant St Date signed 1/6/48 M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G58791
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST.
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 ROLLING RD #27
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS PARKIN SCOTT. SR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife ELIZABETH M. SCOTT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 3, 1873

8. AGE: Years	Months	Days	If less than one day
74	8 9	24 2	hr. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name JOHN W. SCOTT
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ANNA MASSEY
15. Birthplace MARYLAND

16 (a) Informant ADMISSION - SLIP
(b) Address T. PARKIN SCOTT JR. 1524 CHARING CROSS RD

17 Loudon Park (b) Date thereof 1/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave
18 (a) Funeral director Harry F. Witzke
(b) Address 101 Edmondson Ave
19 (a) 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 5 1948 at 6 1/2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1947 to JAN 5 1948 and that I last saw h.i.m. alive on JAN 4 1948.

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to ARTERIOSCLEROSIS	
Due to HYPERTENSION	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elden H. Pentz M. D.
Address Mercy Hosp. Date signed 1/5/48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58792

BC = C88488

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 56E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ Hosp.
(c) Hospital or institution: 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 755 Dover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Ellsworth Wister

3 (b) If veteran, name war No
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) 9/9/194[illegible]

8. AGE: Years | Months: 3 | Days: 26 | If less than one day: hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Harold Wister
13. Birthplace Madison Md

MOTHER
14. Maiden Name Margaret Brown
15. Birthplace Balto Md

16 (a) Informant Margaret Wister
(b) Address 755 Dover St

17 (a) Burial (b) Date thereof 1-7-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Interment
Location Balto Md

18 (a) Funeral director Chas H Corbin
(b) Address 512 N Carrollton Ave.

19 (a) [illegible] (b)
(City or town registrar) (State) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5 1948, at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1948 to 1-5 1948 and that I last saw h[illegible] alive on 1-5 1948.

Immediate cause of death: Toxemia & pneumonia

Due to (or consequence of): Degeneration of Cerebrum, Lymphosarcoma of Abdomen

Due to (or consequence of): epidemic & inguinal ag[illegible]

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Brown M. D.

Address Univ Hosp. Date signed 1-5-48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58793 ✓ 927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 N. Mount St
(c) Hospital or institution: 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 N. Mount St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JEREMIAH WILSON

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Estelle
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11/26/1898
8. AGE: Years 49 | Months 1 | Days 8 | If less than one day hr. min.
9. Birthplace Eastern Shore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jefferson Wilson
13. Birthplace Md

MOTHER
14. Maiden Name Annie Bower
15 Birthplace Md

16 (a) Informant Estelle Wilson(W)
(b) Address 317 N. Mount St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.
18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave
JAN 9 - 1948 (Date rec'd by registrar) (b) Huntington Wilk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4/48 19 , at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1947, to Jan 4 1948, and that I last saw h.i.m alive on Jan 4 1948

Immediate cause of death	Duration
Cardiac Failure	
Due to Valvular Heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. Douglas Sheppard M. D.
Address 6 E Fayette Ave Date signed 1-7-48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

658794 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 58 A. - Westway - N
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** McCarl, Loy H. Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna McCarl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1913

8. AGE: Years	Months	Days	If less than one day
34	5	20	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business

FATHER
12. Name McCarl Loy Sr.
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Pa.

16 (a) Informant Mrs. Anna McCarl
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Rose
Location York Pa.

18 (a) Funeral director Langhan Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date) (b) Registrar
JAN 7 1948 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7/1948, at 11 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1947, to 1/7 1948, and that I last saw him alive on 1/7 1948.

Immediate cause of death: Bronchopneumonia
Thrombosis, renal vein
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq Hosp Date signed 7 Jan 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County a.a.
(c) City or town Crownsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MIRTLE Agatha Moreland
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Richard Moreland
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 10-4-07

8. AGE: Years	Months	Days	If less than one day
40	3	3	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Dallas Madison
13. Birthplace Madison Va Dallas

MOTHER
14. Maiden Name Edinda Phoenix
15. Birthplace Eleano Va Burgess

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/48 (month) (day) (year)
(c) Cemetery or crematory
Location Annapolis Md

18 (a) Funeral director E. Willis Lamasney
(b) Address 1003 W. Baltimore St.

19 (a) JAN 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH Jan. 7, 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1947 to Jan 7 1948, and that I last saw h.lk alive on Jan 07 1948.

Immediate cause of death	Duration
I. Uremia	5 months
Due to Acute glomerulonephritis	
Due to	
Other Conditions Hypertensive cardiovascular disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Gold M. D.
Address JHH Date signed 7 Jan 48

VS 150

120

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 058796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Cambridge St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary F. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Talbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 27th 1891

8. AGE: Years 56 | Months 5 | Days 9 10 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Hayden
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Gaitley
15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave Extended

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 (a) JAN 8 - 1948 (Date rec'd by registrar) (b) Hunting for Williams

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1948 at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to Jan 6 1948, and that I last saw her alive on Jan 6 1948.

Immediate cause of death	Duration
Hypertensive cardio-vascular disease	yr.
Due to ? coronary occlusion	
Due to ? cerebrospinal accident	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Sisson M. D.
Address Johns Hopkins Hosp. Date signed 7 Jan. 48

G58797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G58797

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 N. Hilton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James M. Sinclair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Eva May Sinclair

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13th 1878

8. AGE: Years 69 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Sheet Metal

11. Industry or business Own

FATHER
12. Name James E. Sinclair
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah C. Jenkins
15. Birthplace Balto. Md.

16 (a) Informant James E. Sinclair
(b) Address 210 N. Monastery Ave

17 (a) Burial (b) Date thereof 1/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 JAN 8 1948 (Date rec'd by Registrar) Pd. Cert. for William Cook Inc

VS 150

MEDICAL CERTIFICATION 48

20. DATE OF DEATH Jan 6th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1947, to Jan 6 1948, and that I last saw him alive on Jan 6 1948

Immediate cause of death Carcinoma of stomach

Duration about 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept.

Major findings of operation: carcinoma of stomach.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Paul H. Colbaugh

Address 24 E. Eager St Date signed 1/7/48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~658798~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 98

Registered No. G58798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1023 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter J O'Connor

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Kate M Cotter O'Connor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9th 1858

8. AGE: Years	Months	Days	If less than one day
89	1	19	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Carpenter

FATHER
12. Name Steven O'Connor
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Duff
15. Birthplace Ireland

16 (a) Informant Miss Mary A O'Connor
(b) Address 1023 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 10 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J Coppersmith
(b) Address 961-63 Hollins St.

19 (a) JAN 8 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7th 1948, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5/47 19 , to 1/6/48 19 ; that I last saw him alive on Jan 6 1948.

Immediate cause of death	Duration
Due to Hypertension	2 yrs.
Due to Gangrene of left foot	1 week
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Agnes R. Chandler, M.D.
Address 945 N. Bond St. Date signed 1/7/48

VS 190

X

C58799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. C58799

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI HOSPT 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 PARK HEIGHTS AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosenberg, Ray (RAY)

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife LOUIS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name MOSES GERSUK
13. Birthplace RUSSIA

MOTHER
14. Maiden Name IDA
15. Birthplace RUSSIA

16 (a) Informant HOSPT. RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-8-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd + Hamilton Ave

18 (a) Funeral director JACK LEWIS INC
(b) Address 2480 EUTAW PLACE

19 JAN 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1948 at 10 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1947 to 1-7 1948 and that I last saw her alive on 1-7-1948

Immediate cause of death	Duration
Carcinoma of breast, post-operative,	5 yrs
Due to metastatic	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marion D. Dorn M.D.
Address Same Date signed 1-9-48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. 658800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margareth M. Aidt

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: FM
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1870

8. AGE: Years 77 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business Home

FATHER
12. Name Louis Aidt
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Nau
15. Birthplace Germany

16 (a) Informant Henry J. Aidt
(b) Address 411 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 JAN 8 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1948 at 11.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1948 to Jan 5 1948 and that I last saw her alive on Jan. 5 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days
Due to Arteriosclerosis
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature DeWalter Spurrier M.D.
Address 3603 Edmondson Ave Date signed 1/7/48 M.D.

VS 150

G58801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G58801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 538 W. Biddle Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Artis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1947

8. AGE: Years	Months	Days	If less than one day
	10	-	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lee Artis
13. Birthplace Virginia

MOTHER
14. Maiden Name Lula Leslie
15. Birthplace N.C.

16 (a) Informant Lula Leslie Artis
(b) Address 538- W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave.

19 (a) JAN 8 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1948, at 8.45 P M

21. I certify that I took charge of the remains described above, held an insp.&inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Burns 2-d-3rd degree
75% of body
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-6-48 at 8 p. M.
(b) Where did injury occur? 538 W. Biddle St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Room afire

23. Signature Emily Ruzin M.D. Medical Examiner.
Date signed 1-7-48

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RANGE RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58802

BC-6 28315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G58802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 538 N. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE LESLIE (Lessie)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-15-45

8. AGE: Years	Months	Days	If less than one day
2	5	21	22 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Thomas Leslie
13. Birthplace N.C.

MOTHER
14. Maiden Name Alice Thegpen
15. Birthplace Ga.

16 (a) Informant Alice T Leslie
(b) Address 538 N. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.,

19 (a) Filed 1948 Huntington Williams M.D. (Date received by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1948, at 8.45 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Burns 2nd & 3rd degree
Due to fire

Other Conditions –

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-6-48 at 8 p. M.
(b) Where did injury occur? 538 W. Biddle St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Room afire.

23. Signature Emil L Beyer M.D. Medical Examiner.
Date signed 1-7-48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4000 W. Overlea Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Overlea Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES HABERSACK

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Angelina Habersack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 29, 1864

8. AGE: Years	Months	Days	If less than one day
83	8	8	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Furniture Foreman
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Dora Altvater
(b) Address 911 N. Montford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Road

19 (a) Jan 8 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7th 1948, at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5th 1948 to Jan 7 1948
and that I last saw h[illegible] alive on Jan 5 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	5 hrs
Due to Ulcerative Colitis	2 yrs
Due to Arteriosclerosis	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Bruce M.D.
Address 1 W. Overlea Ave. Date signed 1/8/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registration No. C58803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2916 Violet Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Violet Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Cohen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Late Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER — 12. Name Abraham Lockerwick

13. Birthplace Russia

MOTHER — 14. Maiden Name Rebecca ?

15. Birthplace Russia

16 (a) Informant Mr. Max Cohen

(b) Address 2916 Violet Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 8 48 (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Hamilton Avenue

18 (a) Funeral director Sol Kleinman & Bros

(b) Address 1124-26 W North Ave.

19 (a) [illegible] 1948 (Signature of local registrar) Carrington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1948, at 9:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Jan 7 1948, and that I last saw him alive on Jan 7 1948:

	Duration
Immediate cause of death: Coronary Thrombosis	Unknown
Due to: Acute Gall Bladder attack & Jaundice	4 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lester A. Kahn M. D.

Address 3700 Lash Hughlett Date signed Jan 8 1948

VS 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

G58805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58805 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 n. Gilmore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 n. Gilmore ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Johnson
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex m | 5. Color or race c | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary E. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6 1873

8. AGE: Years 74 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Robert Johnson
13. Birthplace md

MOTHER
14. Maiden Name
15. Birthplace —

16 (a) Informant Mary E. Johnson
(b) Address 1209 Lawton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location md

18 (a) Funeral director George D. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) Date received by Registrar JAN 8 1948 (b) Registrar Winfield for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1948 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27-1947 to 12-31-1948, and that I last saw him alive on 12-31-1948

Immediate cause of death Chronic myocarditis — Duration

Due to

Due to

Other Conditions Cardiac asthma

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 1-7-48

VS 150

G58806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G58806

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1658 mountmore ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1658 mountmore ct (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Blackwell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1932

8. AGE: Years	Months	Days	If less than one day
15	6	3	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name William J. Blackwell
13. Birthplace N. C.

MOTHER
14. Maiden Name martha Wortham
15. Birthplace N. C.

16 (a) Informant William J. Blackwell
(b) Address 1658 Mountmore ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn.
Location Md

18 (a) Funeral director George S. Nelson
(b) Address 1303 Presstman St

19 JAN 8 1948 (Date rec'd by Registrar) Funeral for William J. Blackwell

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7 1948, at 5:1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1948 to 1/7 1948 and that I last saw ___ alive on ___ 19___

Immediate cause of death: Pulmonary Embolism

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 734 N. H. Ave Date signed 1/8/48

VS 150

T 68807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered 68807

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2135 Sinclair Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2135 Sinclair Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT H. CHAMPNESS

3 (b) If veteran, name war ------
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anna Champness
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1870.

8. AGE: Years 77 | Months 3 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired.
11. Industry or business: Butcher.

FATHER
12. Name: Thomas Champness
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Mary Lewald
15. Birthplace: Balto., Md.

16 (a) Informant: Myrtle A. Champness (Daughter)
(b) Address: 2135 Sinclair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1- 9- 48. (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: 4430 Belair Rd.

18 (a) Funeral director: Charles L. Leiter.
(b) Address: 901 S. Conkling St.

19 (a) JAN 8 1948 (Date received by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1948, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1940 to Jan 6 1948. and that I last saw h[illegible] alive on Jan 6 1948

Immediate cause of death	Duration
Pulmonary Oedema	2 hrs
Due to Myocardial degeneration	10 yrs
Due to Herpes Zoster, Rt. Leg.	2 weeks
Other Conditions Decubitus Sore Rt Sacrum & R. Foot Gangrene	1 month

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: William H. Enright M. D.
Address 10 E Biddle St Date signed 1/8/48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G58808 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 S. Sharp Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 1
(e) Length of stay in Baltimore (yrs., mos., or days) (15)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 S. Sharp Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David S. White ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/1890

8. AGE: Years	Months	Days	If less than one day
57	6	2019	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name David C. White
13. Birthplace N.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Virginia Venie
(b) Address 103 Hazelway (Braddock, Pa.)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Ct.
Location Baltimore, City.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery Street
JAN 8 - 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 48

20. DATE OF DEATH January 4, 1947, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1947 to Jan 4 1947 and that I last saw h[illegible] alive on Jan 4 19 47

Immediate cause of death — Duration

Due to Lobar Pneumonia — 9 day
Due to Exposure & Infection
Due to
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Cole Shelton M. D.
Address 918 S. Sharp Date signed 1/8/48

VS 180

G58809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G58809

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Lake Montebello Dr.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie W. (HELMINA) Stewart

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-18-3440

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-11-1881

8. AGE: Years 66 | Months 11 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business Home for Incurables

FATHER
12. Name John J. B. Stewart
13. Birthplace Ohio

MOTHER
14. Maiden Name Minnie Ubert
15. Birthplace Md. - Baltimore

16 (a) Informant Frank P. Stewart (Brother)
(b) Address Kingsville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Stewart & Interment Company
(b) Address 103 W. North Ave. City #1.

19 (a) (Date received by Registrar) Jan 8 1948 Washington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5 1948, at 11.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1947 to 1-5 1948, and that I last saw her alive on 1-5 1948.

Immediate cause of death Cachexia & Respiratory Failure — Duration

Due to Metastatic Carcinoma of the Lungs & Brain

Due to Carcinoma of the Breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ?

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C B Kearney M. D.

Address Univ Hosp Date signed 1-6-48

X

658810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 658810

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Vine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER 12. Name Ned Jones
13. Birthplace Virginia

MOTHER 14. Maiden Name Jenda Grayham
15. Birthplace Virginia

16 (a) Informant Hallie Callahan
(b) Address 1811 N. Gilmore St

17 (a) Burial (b) Date thereof Jan. 8-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brooklyn ave

19 (a) JAN 8 - 1948 (b) Lawrence Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1948, 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1948 to 1/5 1948, and that I last saw he alive on 1/5 1948.

Immediate cause of death Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marcus W. Moore
Address Provident Hospital Date signed 1/6/48 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 130

G58811
AB-12068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58811
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 Mullikin Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30- 1929

8. AGE: Years 18 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Uphostery Work

11. Industry or business

FATHER
12. Name Leroy Howard
13. Birthplace Va.

MOTHER
14. Maiden Name Essie Lee Jones
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elwyn B. Wilson
(b) Address 4000 Bdantry ave

19 (a) JAN 8- 1948 (Date rec'd by registrar) Washington William Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Jan. 8- 1948 at 12.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-11- 1947 to 1-8- 1948 and that I last saw him alive on 1-6- 1948

Immediate cause of death Tuberculosis of lungs far advanced — Duration 7 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Siegfried W. Parker MD M. D.
Address Bell Clg Hosp Date signed 1-9-48

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G58812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Emerald Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 George Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife Jennie Carroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Eastern Shore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Carroll
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Myles Katz.
(b) Address 1900 Edmondson Ave.

17 (a) Burial (b) Date thereof Jan 3 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 8 - 1948 (b) Tamburton Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1947, at 6 55 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FILL OUT AND SIGNED FOR BURIAL

FL - 1[illegible]6813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 97

Registered No. G58813

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Baltimore Crownsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Crownsville State Hospital
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mike Wallace

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1875 ?

8. AGE: Years 73 ? | Months | Days | If less than one day ... hr. ... min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1-12-48
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Washington, D. C.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) JAN 8 1948 (b)
(Date received by registrar) Registrar

V S 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 1948, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1948, to Jan. 7 1948, and that I last saw h[illegible] alive on Jan. 7 1948.

Immediate cause of death (a) Cardio-resp failure — Duration: 2 hrs
Due to (b) Gen. arteriosclerosis — Duration: yrs
Due to (c) — Duration:
Other Conditions arteriosclerotic gangrene of foot Left — Duration: hrs
(Include pregnancy within 3 months of death)

Date of operation ~
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Craft
Address Balt City Hosps Date signed 1/8/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58814 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26-6 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5703 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Billy Gene Hembree

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1943

8. AGE: Years 5 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Truman Hembree
13. Birthplace ?

MOTHER
14. Maiden Name Rochele
15. Birthplace

16 (a) Informant R. Hembree
(b) Address 5703 O'Donnell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location O'Donnell St

18 (a) Funeral director Joseph Lasinski
(b) Address 60 N Washington Ave

19 (a) JAN 8 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1948 at 11.35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Carbon-monoxide Poisoning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26/6
(a) Date of injury 1-6-48 at 11 a. M.
(b) Where did injury occur? 5703 O'Donnell St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Home afire.

23. Signature Howard J. Caussin M.D. Medical Examiner.
Date signed 1-6-48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G58815 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 707 W Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 W Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT RUDVILAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Lithia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Luth

MOTHER
14. Maiden Name ?
15. Birthplace Luth

16 (a) Informant Joseph Rubas
(b) Address 707 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Anundel County

18 (a) Funeral director Joseph Kasunakas
(b) Address 602 Washington Blvd

19 (a) 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1948 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1948 to Jan 6 1948, and that I last saw (was alive on Jan 4 1948

Immediate cause of death: Coronary Occlusion — Duration: sudden

Due to: Coronary Artery Disease — 7 days

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr.
Address 1227 Wash Blvd Date signed 1/9/48

VS 150

G58816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G58816

*PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 Ensor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 1
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Ensor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. Martin

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen T.

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 4 1884

8. AGE: Years 63 | Months 6 | Days 3 | If less than one day: hr. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: John Martin
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Catherine Hannan
15. Birthplace: Ohio

16 (a) Informant: Helen T. Martin
(b) Address: 1204 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 10 48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: 4300 Beloit Rd

18 (a) Funeral director: The Dippel Bros
(b) Address: 1600 E. Lombard St

19 JAN 8 - 1948 (Date rec'd by registrar) (b) Registrar: Huntington Williams

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1948, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1947 to Jan 7 1948 and that I last saw h[illegible] alive on 2 Jan 1947.

Immediate cause of death	Duration
Coronary thrombosis	3 hrs
Due to: coronary artery disease (angina)	2
Due to: arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Samuel Schaefer, M.D.
Address: 714 E Preston Date signed: 8 Jan 48

X

G58817 Fauntleroy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 170c

Register No. G58817

Over

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325- N. Eden Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph T. (Fauntelroy) Fauntleroy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Nannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1899

8. AGE: Years	Months	Days	If less than one day
48	-	13	hr. min.

9. Birthplace St. Marys County Md.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Frank Fauntleroy
13. Birthplace Md.

MOTHER 14. Maiden Name Dora Brown
15. Birthplace Md.

16 (a) Informant Nannie Fauntleroy
(b) Address 325 N. Eden St

17 (a) Burial (b) Date thereof Jan 11/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holly Grove Cemetery
Location St Marys County Md

18 (a) Funeral director Mrs Ella A. Elbrey
(b) Address 1129 N. Carey St

19 JAN 8 - 1948 (by) Hunter for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1948, at 2. a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured pelvis.
Fractured ribs.
Fractured wrist
Contusions and abrasions of head.

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-7-48 at 1 a. 4/1 M.
(b) Where did injury occur? Fayette & Howard Sts. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Truck Driver-struck by auto

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 1-7-48

658818

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 658818

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Bureau St.
(c) Hospital or institution: Baltimore City Jail
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 W. Fayette St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerry Samuel Haller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30-1902

8. AGE: Years	Months	Days	If less than one day
46	6	7	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John A. Haller Sr.
13. Birthplace Virginia

MOTHER
14. Maiden Name Hester L. Jackson
15. Birthplace Virginia

16 (a) Informant John Haller Jr.
(b) Address Winchester Virginia

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Union Forge Cemetery
Location Clifton Forge Va.

18 (a) Funeral director DELLINGER Dellinger Son
(b) Address Woodstock, Va.

19 JAN 8-1948 (Date rec'd by registrar) (b) Huntington Williamsport, W.Va.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 1948, at 6.05 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Rogers M.D. (Medical Examiner)
Date signed 1-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/61

Registered No. C58819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 N. Payson St.
(c) Hospital or institution: --- 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 N. Payson St. (If rural give location)
(e) Citizen of foreign country? -- (Yes or No) If yes, name country --

3 (a) FULL NAME FLORENCE BLANCHE McLAUGHLIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Henry Clay McLaughlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1879

8. AGE: Years	Months	Days	If less than one day
68	5	25	hr. min.

9. Birthplace Chambersburg, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name David Martin Funk
13. Birthplace Penna

MOTHER
14. Maiden Name Mary Ellen Bowers
15 Birthplace Penna.

16 (a) Informant Dr. D.C. McLaughlin-- Son
(b) Address 400 N. Payson St. Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Grove
Location Chambersburg, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto. Md.

19 (a) JAN 8 - 1948 (b) Huntington Williams, M.D. (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1948 xHour, at 3.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947, to Jan 7 1948 and that I last saw her alive on Dec. 10 1947

Immediate cause of death	Duration
Left heart failure	10 hrs
Due to Arteriosclerotic cardio vascular disease	—
Due to Diabetes mellitus	14 yrs
Other Conditions Left hemiplegia	1 yr

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen Lee Magruder M. D.
Address Catonsville 28, Md Date signed 1-8-48

VS 150

X

G58820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1113

Registered No. G58820

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2725 W. Fairmount Ave.
(c) Hospital or institution: 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2725 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Kuhl

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1895

8. AGE: Years 52 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Louis Herman Appel
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Martha Mueller
15. Birthplace: Baltimore, Md.

16 (a) Informant: Charles F. Kuhl-- Husband
(b) Address: 2725 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10 48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~: Moreland Memorial
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC
(b) Address: North & Pa. Balto., Md.

19 (a) JAN 8- 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1948, at 8 20 M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner
Date signed 1-9-48

VS 181

G58821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G58821 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3020 Reisterstown Rd.
(c) Hospital or institution: 15-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADA BABENDREIER

3 (b) If veteran, name war: -
3 (c) Social Security Account No.: -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: Arthur O. Babendreier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1875

8. AGE: Years	Months	Days	If less than one day
72	6	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Ricking
15. Birthplace Germany

16 (a) Informant Mrs. Julia Troutmann
(b) Address Darby, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 8 - 1948 (Date rec'd by registrar) Certificate for Williams

VS 150

MEDICAL CERTIFICATION a.m.

20. DATE OF DEATH Jan. 6, 1948, at 11:25

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to Jan 6 1948 and that I last saw h[illegible] alive on Jan 5 1948

Immediate cause of death: Carcinoma of left kidney — Duration: 1 year.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation May 17, 1947
Major findings of operation: Carcinoma of L. kidney involving small bowel
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Robert F. Pullman M. D.
Address 6 E Biddle St Date signed 1/7/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G58822

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 W. Hayward Ave.
(c) Hospital or institution: -- 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 W. Hayward Ave
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET ELIZEBETH ROGERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
***	***

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Frederick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1874

8. AGE: Years	Months	Days	If less than one day
73	1	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Johnn Nevin
13. Birthplace Ireland

MOTHER
14. Maiden Name Gala ghan
15. Birthplace Ireland

16. (a) Informant William W. Rogers
(b) Address 3909 W. Hayward Ave

17 (a) Burial (b) Date thereof 1/10/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory XXXX St. Peters Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves., Balto, Md.

19 (a) JAN 8 - 1948 (b) Eurlington Williams, M.D.
(Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 1948, at 3:40P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947, to Jan 7 1948, and that I last saw h[illegible] alive on Jan 6 1948.

	Duration
Immediate cause of death Coronary Thrombosis	1 Day
Due to Generalarteriosclerosis	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen F. Shulman
Address 6 E Biddle St Date signed 1/7/48 M. D.

VS 199

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G58823

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 18-4
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 46
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Mallow Hill Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jones, Percy B.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Lena Blacker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1900

8. AGE: Years	Months	Days	If less than one day
47		29	hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Wholesale wrecking Co.

FATHER
12. Name Charles L. Jones
13. Birthplace Albermarle Co., Va

MOTHER
14. Maiden Name Grace Carroll
15. Birthplace Savanah, Ga.

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof Jan. 8, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Forest Lawn
Location Richmond, Va.

18 (a) Funeral director Wm. J. Tiefner & Sons
(b) Address North & Pa. Aves.

19 (a) JAN 8 - 1948 (b) Twitchington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8, 1948 at 1-10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1948 to Jan 8 1948, and that I last saw him alive on Jan 5 1948.

Immediate cause of death
(a) Bronchogenic carcinoma

Due to

Due to

Other Conditions Partial obstruction, rt. Pleural effusion rt.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Percy Jones Jr M. D.
Address Redwood & Greene Sts. Date signed 1/8/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58824

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Townes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-3-93

8. AGE: Years 65 | Months - | Days 3 | If less than one day: hr. min. 83

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name Lucy Jay

15. Birthplace S. Carolina

16 (a) Informant JOHNS HOPKINS HOSPITAL Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location Baltimore, Maryland

18 (a) Funeral director Chas. Sas. H. Hofland

(b) Address 1631 Druid Hill Ave.

19 JAN 8 1948 (a) Date rec'd by Registrar (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 1948, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1946 to Jan 6 1948, and that I last saw her alive on Jan 6 1948.

	Duration
Immediate cause of death: Purulent Pericarditis, Cause? Auricular Fibrillation	10 d.
Due to: Embolus to L. middle cerebral	?
Due to: artery	10 d.
Other Conditions: Hypertensive Cardiovascular Disease (Include pregnancy within 3 months of death)	4 years
Date of operation	
Major findings of operation:	
of autopsy: NOT reported	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T.E. VanMeter M.D.

Address Johns Hopkins Hosp. Date signed 1/6/48

VS 150

830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C58825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 W. Lanvale St
(c) Hospital or institution: 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Charles A. Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-1507

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1909

8. AGE: Years 38 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Harry A. Rogers

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Julia Clemings

15 Birthplace Baltimore, Md.

16 (a) Informant Mr. Harry Rogers

(b) Address 1113 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) (b) Washington Funeral Directors

(Date rec'd by registrar) JAN 8 - 1948

V S 190 1948

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 7, 1948, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1948, to 1-7 1948 and that I last saw h/ alive on 1-7 1948

Immediate cause of death: Acute Coronary Occlusion — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas W. Shellman, M. D.

Address 1543 Penna. Ave Date signed 1-7-48

X

G58826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58826 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1115 Whitelock
(c) Hospital or institution: 133
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Whitelock (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country.

3 (a) FULL NAME JOSEPH H SAMPSON

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 220-09-2672

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mary J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/27/1870

8. AGE: Years	Months	Days	If less than one day
77	1	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business

FATHER
12. Name William Sampson
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Arena Hall Sampson
15 Birthplace Balto. Md.

16 (a) Informant Mary J Sampson (W.)
(b) Address 1115 Whitelock St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) Date received JAN 8 1948 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5/48 19 , at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1948 to 1-5 1948.
and that I last saw h alive on 1-5 1948

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanford D Amoss M. D.
Address 2309 Druid Hill Date signed 1-7-48

X

G58827
BC - 96106

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157a

G58827
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison and Linden Ave
(c) Hospital or institution: Md. Gen. Hosp. 84
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 E. Hoffman St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Rhinehart

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. newborn

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-47

8. AGE: Years | Months 1 mo. | Days | If less than one day ... hr. ... min.

9. Birthplace Md. Gen. Hosp.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Richard E. Rhinehart
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara Belle Loughlin
15. Birthplace New York

16 (a) Informant Richard E. Rhinehart
(b) Address

17 (a) Burial (b) Date thereof Jan. 9-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Maryland

18 (a) Funeral director Burdee Funeral Home
(b) Address 3631 Falls Road

19 (a) JAN 8 1948 (b) Huntington Williams, M.D.
(Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-8-48 19... at 3:41 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8-47 19... to 1-8-48 19..., and that I last saw him alive on 1-8-48 19...

Immediate cause of death	Duration
Gradual collapse	
Due to Staphylococcus aureus	
Due to MENINGOCOCCE	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury

23. Signature Norman C. Webster M.D.
Address Md. Gen. Hosp., Date signed 1-8-48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. C58828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2819 Woodland Avenue
(c) Hospital or institution: 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Woodland Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter DeWitt Agnor

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-10-7351

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Marie Agnor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9-1883

8. AGE: Years 64 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Order Clerk

11. Industry or business Palmer Corp.

FATHER 12. Name Augusta Agnor

13. Birthplace Virginia

MOTHER 14. Maiden Name Annie Almond

15. Birthplace Virginia

16 (a) Informant Mrs. Anna Marie Agnor

(b) Address 2819 Woodland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9-1948 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) JAN 8 1948 (Date received by Registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1948 at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1947 to Jan 6 1948 and that I last saw him alive on Jan 6 1948.

Immediate cause of death	Duration
Cancer of Bladder	12/18/47
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hans O Bubert M. D.

Address 1001 Park Heights Ave Date signed 1/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C58829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 N. Central Ave
(c) Hospital or institution: S-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wesley Woolford
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice Woolford
6 (c) If alive, give age 5 years

7. Birth date of deceased (mo., day, yr.) Nov. 10th 1880

8. AGE: Years 67 | Months 1 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Wesley Woolford
13. Birthplace Md

MOTHER 14. Maiden Name Sarah Jones
15. Birthplace Md

16 (a) Informant Alice Woolford
(b) Address 523 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9th 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Bernard Manis McWright
(b) Address 721 Pisquata St

19 (a) JAN 8 1948 (b) Huntington Williams
Filed by registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1948, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Jan 5 1948.
and that I last saw him alive on Jan 4 1948.

Immediate cause of death Chronic Nephritis
Glomerulo arteriosclerosis
Due to
Due to
Other Conditions Aortic Insufficiency
Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

Duration
about 10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ralph C. Young
Address 724 E. Monument St Date signed 1/7/48

G58830 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G58830

CERTIFICATE OF DEATH ✓54 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 Wilkens Avenue
(c) Hospital or institution: 20-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 Wilkens Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Clifton Reed.

3 (b) If veteran, name war None
3 (c) Social Security Account No. 216-07-8748

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna B. Reed.
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) December 5, 1886

8. AGE: Years 61 | Months — | Days 24 | If less than one day: hr. min.

9. Birthplace Kent County Md. (Town, county and state)
10. Usual Occupation Insurance Agent
11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Margaret Byrne
15. Birthplace Maryland.

16 (a) Informant Anna B. Reed.
(b) Address 2119 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 W. Fredrick Avenue

19 (a) (Date received by registrar) (b) Registrar Huntington Williams M.D.

JAN 8 1948 — 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1948, at 1030 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947, to Jan 6 1948, and that I last saw h— alive on Jan 6 1948.

Immediate cause of death Pulmonary Edema — Duration: 1 day

Due to Medulla - Tumor — Duration: 1 year

Due to — Duration:

Other Conditions Hypertension — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Antonio De Nittis M. D.
Address 2151 Wilkens Ave Date signed Jan 7/48

G58831

BALTIMORE CITY HEALTH DEPARTMENT ✓ X G58831

CERTIFICATE OF DEATH 95c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Allegheny
(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 97 Spring St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Boyd E. Twigg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jeanette Twigg (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 8-2-07

8. AGE: Years: 40 | Months: 5 | Days: 6 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Textile worker

11. Industry or business

FATHER
12. Name Moses, Twigg
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Harris
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Alleghany
Location Frostburg, Md

18 (a) Funeral director John A. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 JAN 9 - 1948 (Date rec'd by Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1948, at 2.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1948 to Jan 8 1948 and that I last saw him alive on June 8 19 48.

Immediate cause of death: Heart failure — Duration: 1 wk.
Due to: Cor pulmonale
Due to: Pulm. emphysema
Other Conditions: Secondary polycythemia
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick M. D.
Address Johns Hopkins Hosp. Date signed 1/5/48

X

558832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 558832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2751 The Alameda
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2751 The Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM NELSON BRADFORD

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Isabel M. (Broring)
6 (c) If alive, give age: 74 years
7. Birth date of deceased (mo., day, yr.): Feb. 4, 1872
8. AGE: Years: 75 Months: 11 Days: 2 If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Ret. 2½ yrs.
11. Industry or business: B & O R.R.

FATHER
12. Name: Thomas N. Bradford
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Ann McAdams
15 Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Isabel Bradford
(b) Address: 2751 The Alameda
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/9/48 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cemetery
Location: Baltimore, Md.
18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY
19 (a) JAN 9 - 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION AM

20. DATE OF DEATH January 8, 1948 at 11.45

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1947, to Jan 6 1948, and that I last saw h alive on 19.

Immediate cause of death	Duration
Myocarditis	14y.
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Ernest Frederick M. D.
Address 1426 N. Washington St. Date signed 1/6/48

VS 150

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Erase or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C58833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 435 N. Linwood Avenue
(c) Hospital or institution: 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 435 N. Linwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES Z. FITCHETT (CHARLES ZIMMERMAN FITCHETT)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-01-8787

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Ella Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 19, 1873

8. AGE: Years 74 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business Lenderking & Co

FATHER
12. Name John Victor Fitchett
13. Birthplace Va

MOTHER
14. Maiden Name Eliza F. Eaton
15 Birthplace Va

16 (a) Informant Mrs Mildred E. Walker
(b) Address 435 N. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1948, at 9:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1947 to Jan 8 1948.
and that I last saw him alive on Jan 8 1948.

Immediate cause of death: Myocardial failure — Duration: 2 days
Due to: Chronic Myocardosis — ?
Due to: Arteriosclerotic Heart Disease — ?
Other Conditions: none
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Francis J. Jannazzeki M.D.
Address 540 N. Linwood Ave Date signed 1/8/48

VS 150

G58834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G58834

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Foster Ave.
(c) Hospital or institution: 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Foster Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA T. KRAUSZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William L. Krausz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/1896

8. AGE: Years 51 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Home

FATHER
12. Name Frederick Hohenstein
13. Birthplace Alexandra Va.

MOTHER
14. Maiden Name Mary Erlbacher
15 Birthplace Germany

16 (a) Informant William L. Krausz
(b) Address 3205 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 12 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St.

19 (a) JAN 9 - 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 1948, at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 46 to Jan. 19 48, and that I last saw her alive on Jan 6 19 48

Immediate cause of death: Cor Pulmonale, Acute — Duration: 1 Hr.

Due to: Hypertensive Heart Disease — Duration: 10 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeDoux M.D.
Address 601 S. Ellwood Ave. Date signed 1/9/48

VS 150

X

G58835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G58835 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NJ (b) County
(c) City or town Cape May
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1275 Lafayette St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Bohm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise Donnelly Bohm

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) October 4, 1879

8. AGE: Years 68 | Months 2 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Henry C. Bohm
13. Birthplace: NJ

MOTHER
14. Maiden Name: Catherine West
15. Birthplace: Philadelphia, Pa.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 10/48 (month) (day) (year)
(c) Cemetery or crematory: Cold Spring Cemetery
Location: Cold Spring N.J.

18 (a) Funeral director: John O. Mitchell Sons
(b) Address: 1400 Eutaw Place.

JAN 9 1948 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1948, at 5:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1947 to Jan. 8 1948 and that I last saw him alive on Jan. 8 1948.

	Duration
Immediate cause of death: Carcinoma of right kidney with metastases to right adrenal, liver and	UNKNOWN
Due to: both lungs	
Due to:	
Other Conditions: Bronchopneumonia right upper lobe	ONE WK.

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: [illegible] van Aekeren, Medical Director, U.S.P.H.S.
Address: Medical Officer in Charge Date signed 1/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

658836 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3135 Mc Elderry Street
(c) Hospital or institution: 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3135 Mc Elderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha J Sollers

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ernest L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 23 1879

8. AGE: Years 68 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown Krall
13. Birthplace .. Balto

MOTHER
14. Maiden Name Unknown
15. Birthplace -

16 (a) Informant Eva Mae Dorsey
(b) Address 3135 Mc Elderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 10 48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location E. North Ave

18 (a) Funeral director Wm Cook Inc
(b) Address 1212 St Paul St.

1948 JAN 9 (Date rec'd by registrar) Registrar for Williams M.D.

VS 151

MEDICAL CERTIFICATION 05

20. DATE OF DEATH January 7, 1948, at 8 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Rogers M.D. (Medical Examiner)
Date signed

G58837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No. G58837

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave + Madison St
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3801 Dolfield Ave # 10
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Hermione C. Schneider

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married.

6 (b) Name of husband or wife Harry C. Schneider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2nd 1884

8. AGE: Years	Months	Days	If less than one day
63	8	5	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Adolph Schmidt
13. Birthplace N. Y.

MOTHER
14. Maiden Name Fredericka Schmidt
15. Birthplace N. Y.

16 (a) Informant Harry C. Schneider
(b) Address 3801 Dolfield Ave

17 (a) Burial (b) Date thereof 1/10/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Extended

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 JAN 9 - 1948 (Date rec'd by registrar) Thos. Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1948, at 11:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1947 to Jan. 7 1948, and that I last saw h.e.r alive on Jan. 7 1948

Immediate cause of death: Cardiac failure
Due to: Acute bronchial asthma
Due to:
Other Conditions: Contact dermatitis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration
At

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. Jarvis Hunt M.D.
Address Maryland General Hospital Date signed 1-8-48

X

G58838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G58838 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT ST.
(c) Hospital or institution: MERCY HOSPITAL 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2437 CALLOW AVE (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME SADIE ROSENBERG

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife ISRAEL ROSENBERG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1880

8. AGE: Years	Months	Days	If less than one day
67	3	7	hr. min.

9. Birthplace LONDON, ENGLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name SAMUEL GOLDSTEIN
13. Birthplace POLAND

MOTHER
14. Maiden Name REBECCA HERZBERG
15. Birthplace POLAND

16 (a) Informant ADMISSION SLIP.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Holmes Woodlawn Rd
Location Woodlawn Blvd

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W Northaven

19 (a) JAN 9 - 1948 (Date rec'd by registrar) (b) Wellington Williams M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 8 1948, at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1947, to 1/8 1948, and that I last saw h.e.r alive on 1/8 1948

Immediate cause of death	Duration
RESPIRATORY AND CARDIAC FAILURE	
Due to CEREBRAL THROMBOSIS	
Due to RHEUMATIC HEART DISEASE	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elden H. Perty M. D.
Address Mercy Hosp. Date signed 1/8/48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6588.39 ✓

6588.39 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 15 6
(b) Street address Rayner Ave & Dukeland St
(c) Hospital or institution:
West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2853 West North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gabriel Hament ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife. Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Austria

MOTHER
14. Maiden Name unknown
15. Birthplace Austria

16 (a) Informant Wm Hament
(b) Address 2912 Ulman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Defair Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place

19 (a) JAN 9 - 1948 (Date rec'd by Registrar) (b) Huntington-Williams Mt

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1948, at 4:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1947, to Jan. 8 1948, and that I last saw him alive on Jan 8 1948.

Immediate cause of death	Duration
Broncho Pneumonia	
Due to	
Due to Congestive Heart Failure	
Arteriosclerotic Heart Disease	
Other Conditions	
Fractured Hip Right	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/6
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec 20 '47 at 8:45 P M
(c) Where did injury occur? Dukeland St Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Street While at work? No
(Specify type of place)
(e) Means of injury Fell on Street

23. Signature E. Robert Hardy
Address Med Bldg Date signed 1/8/48

VS 150

appr 1/9/49 Wm J Williams per Earle Riggin

G58840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G58840 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & William Ave
(c) Hospital or institution: Lakeview Memorial 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs. about
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 John St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Miss Mary E Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4 1858

8. AGE: Years	Months	Days	If less than one day
89 90	1	3	hr min

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Edwin Johnson
13. Birthplace Philadelphia Pa.

MOTHER
14. Maiden Name Caroline Kremer
15. Birthplace Germany

16 (a) Informant Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cathedral
Location Baltimore Md

18 (a) Funeral director Geo Weaver & Son
(b) Address 805 N. Calvert St.

19 JAN 9 - 1948 (Date rec'd by Registrar) (Signature of Registrar) for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7 1948 at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1/47 19 to 1/7 1948 and that I last saw her alive on 1/6 19 48.

Immediate cause of death Cardiac Failure - Hypertension C.V.D.
Due to Bronchopneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H W Mentz
Address Bozman Date signed 1/7/48 M. D.

VS 150

C58841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83

Registered No. C58871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green Spring & Belvedere Ave
(c) Hospital or Institution: Levindale 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Belinsky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Levindale
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 2100 Fontaine Place

19 (a) JAN 9 - 1948 (Date rec'd by Registrar) (b) Transcription from Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1948, at 11? M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1947, to 1-8 1948, and that I last saw h[illegible] alive on 1-8 1948.

Immediate cause of death	Duration
Cerebral Arteriosclerosis	
Cerebral Hemiplegia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Edmund Levin, M.D.
Address Levindale Date signed 1/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓

C. No. 40446

Registered No. C58842

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 2612
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adelaide Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1870

8. AGE: Years	Months	Days	If less than one day
? 77	1	26	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lazerus Kemmerly
13. Birthplace Maryland

MOTHER
14. Maiden Name Hester
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 1/10/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul St.

19 JAN 9 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7th 1948 19 , at 9. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31/ 38 to Jan. 7th 19 48 and that I last saw h er alive on Jan. 7th 19 48

Immediate cause of death cardiac failure — Duration ?

Due to ASCVD — 4 yrs

Due to

Other Conditions senile-trochanteric fracture of femur left — 3 yrs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-17-40 at ? M
(c) Where did injury occur? Gunning — Balto Co. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? no
(Specify type of place)
(e) Means of injury Slipped & fell in Hospital while getting out of bed

23. Signature Gordon Stall M.D.

Address Balt. City Hosp. Date signed 1/7/48

V S 150

WILLIAM H. KAMMER, M.D. PRINTING CO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

X G58843 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27d.
(e) Length of stay in Baltimore (yrs., mos., or days) yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County Baltimore
(c) City or town BALTIMORE 31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8809 HARFORD RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSALIE GRZMALA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Anthony Nieckowski

13. Birthplace Poland

MOTHER 14. Maiden Name Mary

15. Birthplace Poland

16 (a) Informant Karol Miecskowski

(b) Address 8809 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10-48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski

(b) Address 2007 Eastern Ave

19 (a) JAN 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1948 at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1948 to 1-7 1948 and that I last saw her alive on 1-7 1948

Immediate cause of death

Acute myocardial failure

Due to: Arteriosclerotic Heart disease

Due to

Other Conditions Gangrene of L leg

Strangulated femoral hernia

(Include pregnancy within 3 months of death)

Date of operation 12-11-47 - Hernia repair 1-3-48 amputation

Major findings of operation Strangulated femoral hernia

Gangrene L leg

Duration: 27 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stanley B. Klymowicz M.D.

Address St Joseph's Hosp Date signed 1/7/48

V S 150

658844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 658844

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3304 Alto, Rd. 15-1
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE, MD. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 ALTO, RD. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME KATHERINE I. WRENN.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband or wife: AUGUSTUS C. WRENN
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Dec 15, 1884
8. AGE: Years 63 | Months 0 | Days 22 | If less than one day ____ hr. ____ min.
9. Birthplace: MARYLAND (Town, county, and state)
10. Usual Occupation: HOUSEWIFE
11. Industry or business

FATHER
12. Name: WM. T. EASTON
13. Birthplace: DISTRICT of COLUMBIA

MOTHER
14. Maiden Name: SARAH E LUSBY
15. Birthplace: SAVAGE, MD.

16 (a) Informant: MRS. R.C. WHITNEY - SISTER
(b) Address: 2815 WALBROOK AVE
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/10/45 (month) (day) (year)
(c) Cemetery or crematory: LORRAINE
Location: BALTIMORE, MD
18 (a) Funeral director: WM. J. TICKNER & SONS.
(b) Address: North & PA. Aves. Balto, MD
19 (a) JAN 9 1945 (Date rec'd by registrar) (b) Registrar: Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 7 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1939 to Jan 1945 and that I last saw h.m. alive on 1-7 1945.

Immediate cause of death: Coronary Thrombosis
Due to: Cerebral arteriosclerosis
Due to: Great Chronic
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

Duration
1 month
9 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury

23. Signature: C and E Cruikshank M. D.
Address: 2217 South St Date signed 1-8-45

VS 150

X

C58845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1830

Registered No. C58845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fountain & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Juniper Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr Thomas B Aycock

3 (b) If veteran, name war Wold War I

3 (c) Social Security Account No. None

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Irene Aycock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/9/1895

8. AGE: Years 52 | Months 0 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Pikeville, N.C. (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Thomas R. Aycock
13. Birthplace N.C.

MOTHER
14. Maiden Name Bettie Ballance
15. Birthplace N.C.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/48 (month) (day) (year)
(c) Cemetery Lorraine Mausolem
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto., Md.

19 (a) JAN 9 1948 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1948 at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1948 to 1-8 1948 and that I last saw h[illegible] alive on 1-8 1948.

Immediate cause of death Subarachnoid hemorrhage — Duration

Due to Congenital aneurysm

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Subarachnoid hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest H. King M. D.
Address Univ Hosp Date signed 1-9-48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58846 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2323 Aiken St.
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 Aiken St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSIE B. JOHNSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Neal Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1877

8. AGE: Years	Months	Days	If less than one day
70	6	10	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown Langford
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown Newcomb
15. Birthplace Va.

16 (a) Informant Mr. Ernest B. Johnson
(b) Address 2323 Aiken St.

17 (a) Burial (b) Date thereof 1/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 9 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1948, at 1:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from 15-Nov 1945 to 7-Jan 1948 and that I last saw h-e-r alive on 7-Jan 1948.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arteriosclerotic Cardio Vascular Disease	Nov-1945
Due to With hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas D. McEdwards M. D.
Address 2746 Hollander Ridge Date signed 7-Jan-48

G58847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G58847

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Evesham Ave.
(c) Hospital or institution: -- 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) ---

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Ba ltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Evesham Ave.
(If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

3 (a) FULL NAME LAWRENCE HUGH GERTH

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: Yes

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bessie Grth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 29, 1873

8. AGE: Years 74 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Lancaster Co., Pa.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Cross & Blackwell Co.

FATHER
12. Name Frederick Gerth
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Barbour
15 Birthplace Penna.

16 (a) Informant Mr. L.W. Gerth -- Son.
(b) Address 713 Evesham Ave., Balto, Md.

17 (a) Burial (b) Date thereof 1/10/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto; Md.

19 JAN 9 1948 Hunter Williams, M.D.
(Date rec'd) (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1948 (Yr.), at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1941 to Jan 8 1948 and that I last saw h alive on Jan 5 1948

Immediate cause of death: Coronary Thrombosis — Duration: 1 hr
Due to: Arterio-Sclerosis — Gradual
Due to: Myocarditis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Hardy M. D.
Address 1403 Park Ave Date signed 1-9-48

X

Instructions: Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 131 B

Registered No. G58848

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2512 Longwood St.
(c) Hospital or institution: -- 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Juniper Rd. (If rural give location)
(e) Citizen of foreign country? -- (Yes or No) If yes, name country --

3 (a) FULL NAME JULIA ANN KIMBALL

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: --

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1869

8. AGE: Years 78 | Months 1 | Days 17 | If less than one day ....hr. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation --
11. Industry or business --

FATHER
12. Name William P. Kimball
13. Birthplace N.Y.

MOTHER
14. Maiden Name Mary Daughday
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Robert E. Hecht.
(b) Address 3809 Juniper Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery or crematory XXXXX Loudon Park
Location Ba ltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Ba lto, Md.

19 (a) JAN 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1948 19.... at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Dec 1947 to 8 Jan 1948, and that I last saw h.r alive on 8 Jan 1948

Immediate cause of death Uremia — Duration 6 weeks

Due to Chronic glomerulo nephritis — 15 years

Due to Hypertensive vascular disease — 15 years

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jane B. Hecht M.D.
Address 2020 N. Charles St. Date signed 9 Jan '48

G58849

AB-114884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58849

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Casselman Beatty - or- Castleman Beatty

3 (b) If veteran, name war	3 (c) Social Security Account No.
No WO	NoNo

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22- 1864

8. AGE: Years	Months	Days	If less than one day
83	6	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business —

FATHER
12. Name James Beatty
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary L. Goodwin
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof [illegible] (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Son
(b) Address North & Pa. Ave. Balto.

19 (a) JAN 9 - 1948 (Date received by Registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Jan. 7- 1948, at 7.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30- 1947 to 1-7- 1948 and that I last saw him alive on 1-7- 1948

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Fulton the c RPH.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice M. Lyons M. D.
Address Baltimore City Hosp. Date signed 1-7-47

93D

658850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

658850 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 DIVISION ST
(c) Hospital or institution: Provident Hospital, Baltimore MD
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country None

3 (a) FULL NAME Mary Fleming

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Negro	married

6 (b) Name of husband or wife Major Fleming
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16, 1892

8. AGE: Years	Months	Days	If less than one day
55		20	hr. min.

9. Birthplace Gloucester Court House Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Isam Lewis.
13. Birthplace Virginia.

MOTHER
14. Maiden Name Molley Baytop
15. Birthplace Virginia

16 (a) Informant Lolus Martin
(b) Address 911 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St.

19 JAN 9 1948 (Date rec'd by Registrar) (b) Kate R. Williams

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1948, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1948 to 1/5 1948 and that I last saw her alive on 1/5 1948.

Immediate cause of death Hypertension
Cardiac Renal Disease

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William M. Banner
Address 1514 DIVISION St Date signed 1/8/48

G58851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G58851 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 Eutaw ave
(c) Hospital or institution: 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Eutaw ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ellen C. Larkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Thomas J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 - 1882

8. AGE: Years 65 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Campbell
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridgit Lenaven
15. Birthplace Ireland

16 (a) Informant Thomas J. Larkin
(b) Address 714 Eutaw ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12-48 (month) (day) (year)
(c) Cemetery or crematory Mon. Cath.
Location Old Frederick Rd.

18 (a) Funeral director John A. Inglon
(b) Address 3000 E Balto. St.

19 JAN 9 - 1948 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Jan. 1948, at 8:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Atrophic Arthritis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. N. Kamman Jr. M.D. (Medical Examiner.)
Date signed 9 Jan. 1948

X

G58852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G58852

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every question should be answered. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 9r
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 E. 41st Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~husband~~ or wife Lt. Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 1881

8. AGE: Years 66 | Months 7 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Karl Hill
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Schroeder
15. Birthplace Germany

16 (a) Informant Frederick L. Hill
(b) Address 5018 Morello Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12 1948 (month) (day) (year)

(c) Cemetery or crematory St Mary's Sovans.
Location Howland Ave

18 (a) Funeral director John C Moran
(b) Address 3600 E Baltimore St

19 (a) JAN 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1948 at 1 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of left tibia and fibula.

Due to Atelectasis of lungs

Dilatation of intestines.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-25-47 at 27/4 8 45 P. M.
(b) Where did injury occur? Harford Rd & Echodale Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature George F. Merrill M.D.
Medical Examiner.
Date signed 1-9-48

VS 181

G58853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1164E

Registered No. G58853

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 163
(c) Hospital or institution Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Jan, 1944
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Spriggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Seamstress

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Miss Gertrude Rabbe
(b) Address 4015 Pennington Ave

17 (a) Burial (b) Date thereof Jan 10 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.
Location Baltimore

18 (a) Funeral director Manuel Cook & Sykes
(b) Address 1600 W. North Ave

19 (a) JAN 9 - 1948 Washington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1948, at 2.45 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull
Crushed Chest

Due to

Other Conditions Multiple fractures

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/6/48 at about 2.00 P.M.
(b) Where did injury occur? Balto City Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital grounds While at work? No
(d) Means of injury Jumped from Fourth Floor

23. Signature G. J. Turkowski M.D.
Medical Examiner.
Date signed 1/7/48

VS 181

G58854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. X. G58854

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Lodge Farm Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SHIRLEY D. POWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1936

8. AGE: Years 11 | Months 9 | Days 0 | If less than one day ___ hr. ___ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Julian C Powell

13. Birthplace Auburn, West Virginia

MOTHER 14. Maiden Name Mildred M. Shields

15. Birthplace West Virginia

16 (a) Informant Father

(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10, 1948 (month) (day) (year)

(c) Cemetery or crematory Oaklawn

Location Baltimore Co., Md.

18 (a) Funeral director Roland L. Fisher

(b) Address 2110 E. Dundalk Ave.

19 JAN 9 - 1948 (Date rec'd by Registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7-48 1948 at 9:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1- 1947 to 1-7- 1948, and that I last saw h[illegible] alive on 1-7- 1948.

Immediate cause of death: Respiratory failure — Duration

Due to Cerebral edema

Due to Chronic glomerulo-nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex. D. Bell Jr. M. D.

Address 1213 Light St Date signed 1-7-48

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G58855 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2827 Simpson St
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Simpson St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Southey Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Married

6 (b) Name of husband or wife Clara Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1869

8. AGE: Years	Months	Days	If less than one day
78	8	6	hr. min.

9. Birthplace ? Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Southen Bell
13. Birthplace ? Virginia

MOTHER
14. Maiden Name Mary E. Bell
15. Birthplace ? Virginia

16 (a) Informant Mrs Clara Bell
(b) Address 2827 Simpson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 10-48 (month) (day) (year)
(c) Cemetery or crematory W Calvary
Location C. P. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) JAN 9 - 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1947 to Jan 7 1948, and that I last saw h2 alive on Jan 8 1948

Immediate cause of death Cardio. Renal Disease — Duration

Due to — 24yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos A. Johnson M. D.
Address 2329 Guilford Ave Date signed Jan 8 1948

G58856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G58856 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 E Federal St
(c) Hospital or institution: 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 E Federal Street (If rural give location)
(e) Citizen of foreign country? ~~no~~ (Yes or No)
If yes, name country

3 (a) FULL NAME Florance Moore

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1893

8. AGE: Years 54 | Months 5 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace ? Virginia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Winston Spencer
13. Birthplace ? Virginia

MOTHER
14. Maiden Name Mary ?
15. Birthplace ? Virginia

16 (a) Informant Mrs Emma Scott
(b) Address 415 E. Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 10-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. R. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) JAN 9- 1948 (Date rec'd by registrar) Washington Hill Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7-1948, at 9:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1947, to 1-7-1948, and that I last saw h[illegible] alive on 1-7-1948.

Immediate cause of death	Duration
Bronchio Pneumonia	14 dys
with Pleurisy	36 dys
Due to Impact Neuritis	40 dys
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. R. Blake M.D.
Address 1327 N Central Date signed 1-8-48

X

G58857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/80

G58857
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15/1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Portee

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1940

8. AGE: Years	Months	Days	If less than one day
8			hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Tally Portee
13. Birthplace Columbia, S. C.

MOTHER
14. Maiden Name Bessie Day
15. Birthplace Richmond, Va.

16 (a) Informant Mr. Tally Portee
(b) Address 1718 N. Carey St.

17 (a) Burial (b) Date thereof 1/11/'48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh St.

19 (a) JAN 9 1948 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1948, at 7.45 P M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Burns and Shock

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 15/1
(a) Date of injury 1-4-48 at about 10 a. M.
(b) Where did injury occur? 1718 N Carey St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration of home

23. Signature Carl L Ruzzo M.D.
Medical Examiner
Date signed 1-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V170c

Registered No. C58858

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county.)
(d) Street No. 409 N. Parish Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male

5 Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Maggie

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 70 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Hall
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mrs Maggie Hall
(b) Address 409 N Parish St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/'48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh St.

19 JAN 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1948, at 8 50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon, and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart failure; syphilitic aortitis; lung abscess,
Due to Left

Other Conditions Fracture of left tibia; Fract. of left hip; Fract. of pelvis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 12-10-48 at 245 P. M.
(b) Where did injury occur? Pennsylvania Ave. & Pratt Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury "Hit and Run"

23. Signature Louis H. Roy M.D.
Medical Examiner
Date signed 1-9-48

VS 151

G58859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G58859 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 S. Paca Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GETTYSBERG TURNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Marie Turner (Dec.)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1877

8. AGE: Years	Months	Days	If less than one day
70	6	7	hrs. min.

9. Birthplace Anne Arundel Co., Maryland
(Town, county, and state)

10. Usual Occupation Oiler (Retired)

11. Industry or business Davidson Chemical Company

FATHER
12. Name John Turner
13. Birthplace Anne Arundel Co., Maryland

MOTHER
14. Maiden Name Marjorie Chaney
15. Birthplace Anne Arundel Co., Maryland

16 (a) Informant Charles F. Turner
(b) Address 773 W. Cross Street

17 (a) Burial (b) Date thereof Jan. 10, 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Nichols Memo. Ch. Yd.
Location Odenton, Md.

18 (a) Funeral director THOMAS W. SINGLETON
(b) Address Glen Burnie, Maryland

19 (a) JAN 9- 1948 (Date rec'd by registrar) Huntington for Millington, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1948 at 11:25AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1-7-48

VS 131

TYPE OR PRINT IN PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1832

Registered No. G58860

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32 S. Franklintown Road
(c) Hospital or institution: ********** 10-4 ******
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 S. Franklintown Road
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE M. HOENES

3 (b) If veteran, name war ********** | 3 (c) Social Security Account No. *********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles W. Hoenes
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1874

8. AGE: Years	Months	Days	If less than one day
73	11/12	6	********** min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business At Home

FATHER
12. Name Charles H. Lang
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Schuermann
15. Birthplace Germany

16 (a) Informant Mr. Charles Lang
(b) Address 32 S. Franklintown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE...17

19 (a) Jan 9 1948 (b) Registered by record Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 6th, 1948, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1947 to 1/6 1948, and that I last saw h alive on 1/6 1948.

Immediate cause of death	Duration
Cerebral Accident	12 hr.
Due to Arteriosclerosis	?
Due to Hypertension	6 yr?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward C Bogorad M. D.
Address 1905 W. Baltimore St. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58861 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts
(c) Hospital or institution: University Hospital 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore # 29 (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 N. Augusta Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marie T. Sulka - "MARIE T. SULKA."

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-9288

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Frederick T. Sulka

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 12/16/1915

8. AGE: Years 32 | Months 1 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace York, Pa. (Town, county, and state)

10. Usual Occupation Laundry Work

11. Industry or business Dressing Room

FATHER
12. Name Albert Weaver
13. Birthplace York, Pa

MOTHER
14. Maiden Name Rosanna Gallagher
15. Birthplace York, Pa

16 (a) Informant Frederick T. Sulka
(b) Address 921 - N. Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 Jan. 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Catherine
Location Baltimore, Md.

18 (a) Funeral director P. D. Wilbert & Son
(b) Address 1300 Eutaw Place

19 (a) JAN 9 - 1948 (Date rec'd by registrar) (b) Huntington Willi[illegible]

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7/48 19 at 5 M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/6/48 19 to 1/7/48 19, and that I last saw h[illegible] alive on 1/7/48 19

	Duration
Immediate cause of death: Respiratory failure	
Due to: Bronchial pneumonia	
Due to: Tuberculosis of lungs - extensive	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 1/7/48

G58862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G58862

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave. 215
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Joe Yeoman - John J. Yeoman

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-5095

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 6, 1918

8. AGE: Years	Months	Days	If less than one day
29	8	6	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Gunsmith

11. Industry or business Penn Rubber Stamp Co.

FATHER
12. Name Edward Yeoman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Bauch
15. Birthplace Germany

16 (a) Informant Mrs. Rose Yeoman
(b) Address 2200 Wilkens Ave.

17 (a) Burial (b) Date thereof 1-10-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director F. B. Wisbert & Son
(b) Address 1200 Eutaw Place

19 (a) Date rec'd 1-9-48 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1948, at 5:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1948 to 1-7 1948, and that I last saw him alive on 1-7 1948

Immediate cause of death — Cardiac failure Congenital Heart + Elevated Fallot

Due to Tetralogy of Fallot

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]

Address [signature] Date signed 1/7/48

M. D.

G58863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V124a

Registered No. G58863

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 15-3
(b) Street address Caton & Hilton Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? Well (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Maurice J. McNeville - "MAURICE J. McNEVILLE"

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-1486

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 21, 1891

8. AGE: Years	Months	Days	If less than one day
56	6	17	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Mfg Worsted

FATHER
12. Name Joseph Neville
13. Birthplace Wisconsin

MOTHER
14. Maiden Name Rose Bondage
15. Birthplace Maryland

16 (a) Informant Raymond Neville
(b) Address 106 S. Louden - Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 Jan 48 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Baltimore Md

18 (a) Funeral director H. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 (a) JAN 9 - 1948 (Date rec'd by registrar) (b) Registrar for Williamsville

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1948 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1948 to 1/7 1948, and that I last saw him alive on 1/7 1948.

Immediate cause of death Cardiac Failure - Delerium Tremens

	Duration
Due to Alcoholic encephalopathy	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Hurwitz M.D.
Address Pagers Date signed 1/7/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G58864 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1924 W. Baltimore
(c) Hospital or institution: 2b-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN Klopfel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-11-1876

8. AGE: Years 71 | Months 6 | Days 28 | If less than one day — hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Herman Klopfel

13. Birthplace Germany

MOTHER 14. Maiden Name Emma H. Wattenschott

15. Birthplace Germany

16 (a) Informant Miss Bertha Klopfel

(b) Address 1924 W. Baltimore St

17 (a) Burial (b) Date thereof 12 Jan 48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director F. Bellifant & Son

(b) Address 1300 Eutaw Pl.

19 (a) JAN 9 - 1948 (b) Funeral to Baltimore Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1948 to 1/8 1948, and that I last saw him alive on 1/8 1948

Immediate cause of death	Duration
Cerebral Accident	3 hrs.
Due to Arterial Sclerosis	?
Due to Hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel E. Bogorad M.D.

Address 1905 W. Balto St. Date signed 1/9/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

Registered No. 658865

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 N Madeira St 8-4
(c) Hospital or institution: Md Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 N Madeira (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank J. ~~Simmsich~~ Sinnreich

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kate Sinnreich

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Nov 11th 1893

8. AGE: Years 54 | Months 1 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Estimator

11. Industry or business marine

FATHER
12. Name Jos Sinnreich
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Kate Sinnreich
(b) Address 1509 N Madeira St

17 (a) Balto Bur. (Burial, cremation, or removal) Date thereof Jan 12. (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Homes
(b) Address 2005 Eastern Av

19 (a) JAN 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Jan, 1948, at 8:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D. Medical Examiner.
Date signed 6 Jan. 1948

VS 151

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 46E

Registered No. 058856

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts, Balto.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) 3mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. (b) County Md.
(c) City or town [redacted] E. Killingly, Conn.
(If outside city or town limits, write RURAL and give town)
(d) Street No. [redacted]
(If rural give location)
(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

3 (a) FULL NAME Mrs John William McDonald (Adelaide) (Adelaide Hopkins McDonald)

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John William McDonald
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) June 2, 1862

8. AGE: Years 84 | Months 7 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Connecticut, Woodstock
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Geo. O. Hopkins
13. Birthplace Rhode Island

MOTHER
14. Maiden Name Sarah Sabah E Wade Wade
15. Birthplace Rhode Island

16 (a) Informant Mrs. George P. Norris (dghtr)
(b) Address 3940 Cloverhill Road, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 - 12 - 48 (month) (day) (year)
(c) Cemetery or crematory Elm Grove
Location Mystic, Conn.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave. - City

19 (a) [illegible] (Signature of registrar) Kenneth Worthington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1948, at 8 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1947 to Jan 9 1948, and that I last saw her alive on Jan 9 1948

Immediate cause of death: Respiratory Failure — Duration

Due to: Carcinoma - Hepatic Collapse

Due to: Heart Decompensation

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation Jan 8, 1948
Major findings of operation: Extended Carcinoma of stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Ashburn M.D.
Address John Ashburn Union Memorial Hospital Date signed 1/9/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

058867 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Charles Street
(c) Hospital or institution: at Home 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Warrington Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Marburg

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-19-1860

8. AGE: Years 87 | Months 11 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name William A. Marburg
13. Birthplace Germany

MOTHER
14. Maiden Name Christine Munder
15. Birthplace Maryland

16 (a) Informant Mr. E. Grainger Marburg (nephew)
(b) Address Lutherville, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Jan-12-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave., City #1

19 (a) JAN 9 - 1948 (Date rec'd by registrar) Chas. Livingston Willis, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1948, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1938 to Jan 9 1948. and that I last saw her alive on Jan 8 1948.

Immediate cause of death: Arterio-Sclerosis Myocarditis — Duration: Fractional V

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Mosby M. D.
Address 1403 Park Ave. Date signed 1-9-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct are is especially important. Physicians: please write the cause of death clearly and legibly.

G58868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 186a

Registered No. G58868

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 Evesham Ave.
(c) Hospital or institution: home 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) abt. 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Evesham Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Eleonora Glaser

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Glaser
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. -1-1860

8. AGE: Years 87 | Months 3 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Paris - France
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Adolph Blum
13. Birthplace Germany

MOTHER
14. Maiden Name Louise de l'Oise
15. Birthplace Paris - France

16 (a) Informant Mrs. Johannes Matteson (Daughter)
(b) Address 606 Evesham Ave. - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 - 10 - 48 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (E. F. Monroe Sec.) 100 W. North Avenue

19 (a) JAN 9 - 1948 (Date rec'd by registrar) Timothy Nolan

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 1948, at 4:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1948 to Jan. 7 1948, and that I last saw her alive on Jan. 7 1948.

	Duration
Immediate cause of death: Pulmonary Edema	3 hrs
Due to: Chronic Myocarditis	2 yrs.
Due to:	
Other Conditions: Fractured of Femur	2 wks.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence January 5, 1948 ? M
(c) Where did injury occur? 606 Evesham Avenue (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell to floor after slipping

23. Signature Dr. McCole
Address 6014 York Road Date signed 1-9-48. M. D.

VS 150

Lot 1157 Thomas J. Mancini, M.D.

C-48-00283

58869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 58869

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution: Woman's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Baltimore Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 6 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Cromwell.

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation -

11. Industry or business -

FATHER 12. Name Harry Marshall Cromwell

13. Birthplace Woodbine, Md.

MOTHER 14. Maiden Name Betty Ruth Jennings

15. Birthplace Westbrina Hyack N. Y.

16 (a) Informant Hospital Records.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-48 (month) (day) (year)

(c) Cemetery or crematory Poplar Springs

Location Poplar Springs Howard Co. Md

18 (a) Funeral director C. M. Watts

(b) Address Woodbine, Md.

19 (a) JAN 9 1948 (Registered by Registrar) (b) Huntingtown Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1948 at 1 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1947, to Jan 8 1948, and that I last saw him alive on Jan 8 1948.

Immediate cause of death	Duration
Respiratory failure.	
Due to Cerebral Hemorrhage	
Due to Birth injury	
Other Conditions None.	

(Include pregnancy within 3 months of death)

Date of operation -

Major findings of operation: -

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vernon G. Kelly M. D.

Address Woman's Hospital Date signed Jan 8, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G58870 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2262 Cedley ave. 253
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2262 Cedley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Grant Pindell.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Eugenie | 6 (c) If alive, where? Deceased

7. Birth date of deceased (month) Mar (day) 13 (year) 1874

8. AGE: Years 73 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Louis Pindell
13. Birthplace Phila. Pa.

MOTHER 14. Maiden Name Amanda —
15. Birthplace Phila Pa.

16 (a) Informant A. Pindell
(b) Address 2262 Cedley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-49 (month) (day) (year)

(c) Cemetery or crematory Balto
Location E. North Ave.

18 (a) Funeral director Geo Leimbach
(b) Address 1214 N. Fremont Ave

19 (a) JAN 9 1949 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1949, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1949 to 1/9 1949 and that I last saw him alive on 1/8 1949.

Immediate cause of death Carcinoma of Bowel — Duration 3 Months

Due to —

Due to

Other Conditions Arteriosclerosis - Heart (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Lotzfeld M.D.
Address 1210 Arlington Date signed 1/11/49

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658871 BC-48-00028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 658871

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital 776
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5606 Fair Oaks Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Krebs Harry Alphonsus Krebs

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4-1948

8. AGE: Years	Months	Days	If less than one day
		4 3	hr. ..... min.

9. Birthplace Sinai Hospital - Md
(Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Louis C. Krebs
13. Birthplace Md.

MOTHER
14. Maiden Name Anna L. Finke
15. Birthplace Md

16 (a) Informant Mr. L. C. Krebs
(b) Address 5606 Fair Oaks Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Md.

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) JAN 9 - 1948 (Date rec'd by registrar) (b) Certified for Williams, M.D.

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7- 1948, at 8.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....,
and that I last saw h..... alive on ..... 19.....

Immediate cause of death:	Duration
Transposition of the Aorta & pulmonary valve	From birth
Due to Pulmonary Hemorrhage	From birth
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Leo M. Seltzer
Address Sinai Hosp. Date signed 1-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248

Registered No. 658872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1156 N. Carey St
(c) Hospital or institution: 162
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1156 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amos O. Hill

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-3653

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jessie B. Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 71 Months 10 Days If less than one day hr. min.

9. Birthplace Mt. Winnas (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name George Hill

13. Birthplace Harford Co Md

MOTHER 14. Maiden Name Catherine Rideout

15. Birthplace Md

16 (a) Informant Jessie B. Hill (wife)

(b) Address 1156 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11-47 (month) (day) (year)

(c) Cemetery or crematory Mt Lion Cemetery

Location Laurel Md

18 (a) Funeral director Brown

(b) Address 1463 N. Carey St

19 (a) JAN 9 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1948 at 1.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12-1947 to 1-8-1948 and that I last saw him alive on 1-7-1948

Immediate cause of death Tuberculosis of Liver

Due to with no significance

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manfred Jones

Address 1303 N. Fremont Ave Date signed 1/9/48 M. D.

VS 150

G58873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G58873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 W. Saratoga street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 W. Saratoga street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: MISS MARY ZINK

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1872

8. AGE: Years	Months	Days	If less than one day
75	10	1	hr. min.

9. Birthplace Elkridge, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Conrad Zink
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Weaver
15. Birthplace Maryland

16 (a) Informant Mr. Charles A. McClung
(b) Address 2001 W. Saratoga st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/48 (month) (day) (year)
(c) Cemetery or crematory Grace Cemetary
Location Elkridge, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 JAN 9 - 1948 (Date rec'd by Registrar) Hattie Lee Williams M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1948, at 5.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/23/ 1947, to 1/7/ 1948, and that I last saw her alive on Jan. 7, 1948.

Immediate cause of death: Heart failure — Duration: 3 wks.
Due to: Rheumatic heart disease — Duration: ?
Due to — Duration:
Other Conditions — Duration:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George A. Kripp M. D.
Address 3030 Edmondson ave. Date signed 1/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

Registered No. 58874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Winston (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis B. French — Francis Raymond French

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7, 1884

8. AGE: Years 63 Months 1 Days 2 If less than one day ....hr. ....min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation Expediter

11. Industry or business

FATHER
12. Name James French
13. Birthplace Virginia

MOTHER
14. Maiden Name Mollie B. Price
15. Birthplace Maryland

16 (a) Informant Son
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-48 (month) (day) (year)
(c) Cemetery or crematory
Location Bethesda Md.

18 (a) Funeral director W. B. Pumphrey
(b) Address Bethesda Md.

19 (a) JAN 9 - 1948 (Date received by registrar) (b) Huntington Hills

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1948, at 9:47 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1947 to Jan 7 1948, and that I last saw h.i.m alive on Jan 7 1948

Immediate cause of death Toxic Hepatitis — Duration Several weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at .... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Favaro

Address Mercy Hosp Date signed 1/9/48 M.D.

VS 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ G58875

Registered No. 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Balto.~~ Hereford
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Burton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/18/1885

8. AGE: Years	Months	Days	If less than one day
62	8	21	hr. min.

9. Birthplace N. Y.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name — Salisbury
13. Birthplace N. Y.

MOTHER
14. Maiden Name Susan Thayer
15. Birthplace N. Y.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/48 (month) (day) (year)
(c) Cemetery or crematory Loetaris
Location Marlton, Md

18 (a) Funeral director Howard S. Mathias
(b) Address White Hall, Md

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

JAN 9 - 1948

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1948, at 9:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull with intra-cranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-7-48 at 10:15 A.M.
(b) Where did injury occur? Parkton & York Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Auto and Auto Collision

23. Signature M.D.
Medical Examiner.
Date signed 1-9-48

X

588876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 131a

Registered No. 588876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1828 W. Lanvale Street
(c) Hospital or institution: ———
(d) Length of stay in hospital or inst. (yrs., mos., or days) ———
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Parole near Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. Parole near Annapolis
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Estelle Snowden

3 (b) If veteran, name war ———
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ———
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day ——— hr. ——— min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business None

FATHER
12. Name Thomas Snowden
13. Birthplace West Minister Md.

MOTHER
14. Maiden Name Elizabeth Dennis
15. Birthplace West River, Md.

16 (a) Informant Mattiel Carter
(b) Address 1828 W. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-1948 (month) (day) (year)
(c) Cemetery or crematory Brewer Hill
Location West St. Extended Annapolis, Md.

18 (a) Funeral director Mrs. Charles E. Hicks
(b) Address 43-45 Northwest St. Annapolis, Md.

19 (a) JAN 10 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1948 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1947 to 1-8 1948 and that I last saw h alive on 1-8 1948.

Immediate cause of death Hypertension
Cardio-Renal-
Vascular

Due to ———

Due to ———

Other Conditions ———

(Include pregnancy within 3 months of death)
Date of operation ———
Major findings of operation: ———
of autopsy ———

Duration: 10 Yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ———
(b) Date of occurrence ——— at ——— M
(c) Where did injury occur? ——— (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ——— While at work? ——— (Specify type of place)
(e) Means of injury ———

23. Signature B. N. Hebden
Address 1225 Park Ave Date signed 1/8/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G58877

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 East 33rd St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 East 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Selena D. Peterman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9 1859

8. AGE: Years	Months	Days	If less than one day
88	2	0	hr. min.

9. Birthplace York, Pa
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Andrew Peterman
13. Birthplace York Co. Pa

MOTHER
14. Maiden Name Rebecca Hershey
15. Birthplace York Co. Pa

16 (a) Informant Warren W Hassler
(b) Address 1703 E. 33rd St Balto

17 (a) Removal (b) Date thereof 1/12/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lutheran
Location Glen Rock, Pa.

18 (a) Funeral director Hafelfinger
(b) Address Glen Rock, Pa.

19 JAN 10 1948 Hunter Stone Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9/48 19 1028 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/46 19 to 1/9/48 19, and that I last saw him alive on 1/9/48 19

Immediate cause of death	Duration
(a) Coronary Thrombosis	15 min
Due to (b) Arteriosclerosis	3 yrs
Due to (c) Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Thompson M. D.
Address 1710 E 33rd Date signed 1/9/48

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 058878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 N. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: AGNES KISH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or ~~wife~~: Joseph Kish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1881

8. AGE: Years 66 | Months - | Days 24 | If less than one day hr. min.

9. Birthplace: Hungary (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Tatay
13. Birthplace: unknown

MOTHER
14. Maiden Name: unknown
15 Birthplace: unknown

16 (a) Informant: Mr. Frank J. Kish - son
(b) Address: 2906 Shirey Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~: Baltimore
Location: North Ave. & Rose St. Balto. Md.

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601-3-5 E. Madison Street

19 (a) JAN 10 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7/48 19 , at 9:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/ 1948 to 1/7/48 19 , and that I last saw h.ER alive on 1/7/48 19

Immediate cause of death: Pulmonary Embolism

	Duration
Due to: Bronchopneumonia &	
Due to: Carcinomatosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: A. Friedman M. D.
Address: Sinai Hosp. Date signed 1/7/48

VS 150

G58879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G58879 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3112 Fait Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Fait Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Jansen

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1873

8. AGE: Years	Months	Days	If less than one day
74	3	18	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation –
11. Industry or business –

FATHER
12. Name John Holston
13. Birthplace Baltimore

MOTHER
14. Maiden Name Christine Rose
15. Birthplace Baltimore

16 (a) Informant Lillian Sheeler
(b) Address 3112 Fait Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Parkwood

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (d) JAN 10 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 19 48 at 5:20AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 47 to Jan 8 19 48 and that I last saw her alive on Jan 8 19 48

Immediate cause of death Cerebral Hemorrhage, Left Hypertension –
Due to Myocarditis –
Arteriosclerosis

Duration
1948
1947
1947

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Sheehan
Address 3436 Bank Date signed 1/8/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G58880 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 East 26th Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 East 26th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertie T. Monosmith

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1876

8. AGE: Years	Months	Days	If less than one day
71	6	6	hr. min.

9. Birthplace Harrisburg, Pa. (Town, county, and state)
10. Usual Occupation Milliner
11. Industry or business

FATHER
12. Name John W. Monosmith
13. Birthplace Shiremanstown, Pa.

MOTHER
14. Maiden Name Sarah A. Oyler
15. Birthplace Chambersburg, Pa.

16 (a) Informant Allan E. Ensor
(b) Address 2404 Erdman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10-48 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Loudon Park

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JAN 10 1948 (Date rec'd by registrar) (b) [illegible] Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1948, at 4:25PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26, 47. to Jan. 7th. 48., and that I last saw her alive on Jan. 7th. 48.

Immediate cause of death	Duration
Myocarditis	unknown
Due to --------	
Due to	
Other Conditions Arteriosclerosis,	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. W. Margetrogou M.D.
Address 401 E. 25th. St. Date signed 1/10/48.

58881

BALTIMORE CITY HEALTH DEPARTMENT X 567 ✓ Registered No. 58881

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town York
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Robert Williams
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
(b) Name of husband or wife Beulah Waltz Williams
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 17th 1903
8. AGE: Years 44 | Months 0 | Days 22 | If less than one day hr. min.
9. Birthplace York Pa. (Town, county, and state)
10. Usual Occupation Stock Clerk
11. Industry or business York Corp.

FATHER
12. Name Chas. H. Williams
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Shaffer
15. Birthplace Pa

16 (a) Informant Sister
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Rose
Location York Pa.
18 (a) Funeral director William Cook Inc.
(b) Address 127 E. Paul St
19 (a) JAN 10 1948 (Date rec'd by registrar) (b) [illegible] for Williams [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9-48 19 , at 4.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1947 to 1-9 19 48 and that I last saw h i m alive on 1-8-48 19

	Duration
Immediate cause of death Resp. Failure	
Due to Diseased Both Pneumonia	
Due to Paraenteritis Meningitis	
Other Conditions Arteriosclerosis Uremia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Hahn M. D.
Address University Hosp Date signed 1-9-48

VS 150

X

G58832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G58832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3832 St Margaret St
(If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Orner

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 9-30-05

8. AGE: Years 42 | Months 3 | Days 9 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Taylor
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Eglein
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery or crematory Rolling Green
Location Harrisburgh Pa.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St

19 (a) JAN 10 1948 (Date rec'd by registrar) (b) Certificate for Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1948, at 1 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1947 to Jan 9 1948 and that I last saw her alive on Jan 9 1948

Immediate cause of death Uraemia — Duration

Due to Stricture Ureters

Due to Carcinoma of the cervix, uteri, Treated

Other Conditions Metastatic Carcinoma

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Glenn B. Rice

Address Johns Hopkins Hosp, Date signed 1-[illegible] M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G58883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 759 Bartlett Avenue
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 759 Bartlett Avenue
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Maryland
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel D. Zink

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Urban Zink
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1904

8. AGE: Years	Months	Days	If less than one day
43	-	11	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edwin Roane
13. Birthplace Virginia

MOTHER
14. Maiden Name Gertrude Groom
15. Birthplace Virginia

16 (a) Informant Urban Zink
(b) Address 759 Bartlett Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10-48 (month) (day) (year)
(c) Cemetery or crematory Cemetary
Location Parkwood

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JAN 10 1948 (Date rec'd by registrar) (b) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1948, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1948, to Jan 8 1948, and that I last saw her alive on Jan 4 1948.

Immediate cause of death	Duration
Carcinoma of uterus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Edward Dees M.D.
Address 125 S. Broadway Date signed 1/8/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G58884

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 W Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Elizabeth Quill

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1888

8. AGE: Years	Months	Days	If less than one day
60	-	-	hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business —

FATHER
12. Name Thomas Quill
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Smother
15. Birthplace Md.

16 (a) Informant George Quill
(b) Address 612 W. Lafayette Ave

17 (a) BURIAL (b) Date thereof 1-12-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Mrs. Frances A. Hensley
(b) Address 518 N. Biddle St

19 (a) JAN 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1948, at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1948 to Jan 8 1948, and that I last saw her alive on Jan 8 1948.

	Duration
Immediate cause of death Cardiac Failure	6 days
Due to Anasarca	?
Due to Ovarian Fibroid	?
Other Conditions Arterio-sclerosis	?

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
Ovarian Fibroid
of autopsy: Hypertrophied heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address St. Joseph's Hospital Date signed 1-9-48

V S 150

56a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 058885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 Vine Street
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Vine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA COOK

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Arthur R. Cook
(b) Address 702 Vine St.

17 (a) Burial (b) Date thereof 1-12-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 10 1948 (b) Clinton Jr. Williams M.D. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Jan 7, 1948, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to Jan 6 1948 and that I last saw her alive on Jan 6 1948.

	Duration
Immediate cause of death: Acute Cardiac Dilatation	Hrs. Days
Due to: Hypertension Cerebrovascular Disease	2
Due to:	1
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Sherman M. D.
Address 753 N. Fulton Ave Date signed Jan 8 1948

658886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658886

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1331 Mosher Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 Mosher Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MATTHEW BELL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1897

8. AGE: Years 50 | Months 49 | Days 10 | If less than one day: 13 hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Eddie Bell Powell
(b) Address 1331 Mosher Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

19 (a) 1-10-1948 (Registered by registrar) (b) [illegible] for Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1948 to 1-9 1948 and that I last saw h[illegible] alive on 1-5 1948.

Immediate cause of death: Chronic Cardio-vascular Renal Disease — Duration: 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Signed 1/14/48

058887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 058887

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1428 Park ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Park ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Sterett Gittings

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1861

8. AGE: Years 86 | Months 7 | Days 2 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Richard J Gittings
13. Birthplace Balt Co Md

MOTHER
14. Maiden Name Victoria Sellman
15. Birthplace Woodlawn A. G. Co Md

16 (a) Informant Mary Sterett Gittings
(b) Address 1428 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12 1948 (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem
Location Balto Md

18 (a) Funeral director Henry N. Jenkins Son Co
(b) Address 10 Cullot Orchard St Baltimore, Md

19 (a) JAN 10 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1948, 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Decemb 1948 to Jan 9 1948, and that I last saw h alive on Jan 9 1948

Immediate cause of death Respiratory failure — Duration

Due to Arteriosclerotic cardio-vascular renal disease

Due to

Other Conditions Hemiplegia left

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Shorofsky M.D.

Address 601 N. Monroe St Date signed 1/9/48

VS 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH

058888 / 058888 Registered No. 1318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 Maple Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARENCE HATFIELD

3 (b) If veteran, name war

3 (c) Social Security Account No. 579-07-8835

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Mamie Hatfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 1898

8. AGE: Years 49 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation PAINTER

11. Industry or business PAINTING

FATHER
12. Name Henry Hatfield
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mamie Hatfield
(b) Address 27 Maple Ave Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Catonsville Md

18 (a) Funeral director Lynch Mortuary
(b) Address Catonsville Md

19 JAN 10 1948 Hunter for Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1948, at 4.50 A M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection / Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uremia

Due to Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. Medical Examiner.
Date signed 1-8-48

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C58889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Highland
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman L Simon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Carrie Simon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-1890

8. AGE: Years	Months	Days	If less than one day
57	11	28	hr. min.

9. Birthplace Highland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Geo H Symon
13. Birthplace Md

MOTHER
14. Maiden Name Amanda Brinkman
15. Birthplace Md.

16 (a) Informant Wallace Simon
(b) Address Highland Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-48 (month) (day) (year)
(c) Cemetery or crematory St Marks
Location Highland

18 (a) Funeral director T C Higginbotham
(b) Address Ellicott City Md

19 JAN 10 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/48 19 , to 1/8/48 19 , and that I last saw h alive on 1/8/48 19

Immediate cause of death	Duration
Cardiac failure	6 mo
Due to Post operative Pericardectomy	1 day
Due to Constrictive Pericarditis	6 mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1/4/48
Major findings of operation: Constrictive Pericarditis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J L Baumgartner M. D.
Address University Hosp Date signed 1/8/48

VS 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 58890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3606 Clipper Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARYANNA MARCISZONEK (MARSONEK)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Unknown

8. AGE: Years 65 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Torun, Poland
(Town, county, and state)

10. Usual Occupation Household

11. Industry or business

FATHER
12. Name Michael Marzec
13. Birthplace Torun, Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Helen Cieslik
(b) Address 2506 Fait Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1805 Eastern Avenue

19 (a) JAN 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1948, at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1948 to Jan. 7, 1948 and that I last saw her alive on Jan. 7, 1948;

	Duration
Immediate cause of death: Cardiac Failure	Immed.
Due to: Chronic Myocarditis	months
Due to:	
Other Conditions: Diabetes	?

(Include pregnancy within 3 months of death)

Date of operation: None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Frank M. Ogden M. D.
Address 2701 N. Calvert St. Date signed Jan. 9, 1948

VS 150

937

G58891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77c

Registered No. G58891

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5 1/2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 270 N. Exeter Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALMA BROOKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Elijah Brooks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name A. Raleigh
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Elijah Brooks
(b) Address 270 N. Exeter at

17 (a) Burial (b) Date thereof 1/14/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lut. Cabvery
Location

18 (a) Funeral director Leroy A. Wilson
(b) Address 1000 Brantly Ave

19 (a) JAN 10 1948 Leroy A. Wilson for Williams, Hill
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1948, at 8.40P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Reyer M.D.
Medical Examiner

Date signed 1-5-48

VS 151

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C58892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor + Winkelman av
(c) Hospital or institution: West. Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 127 N. Potomac St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA L AVERY

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Andrew N.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1 – 1870

8. AGE: Years 77 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER 12. Name Carl N. Witt

13. Birthplace Germany

MOTHER 14. Maiden Name Dorothea Rebow

15. Birthplace Germany.

16 (a) Informant Carl N. Avery

(b) Address 127 N. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12/48 (month) (day) (year)

(c) Cemetery or crematory St. John's Episcopal

Location Shadyside Md.

18 (a) Funeral director John J. Moran

(b) Address 3[illegible] E. Balto. St.

19 (a) JAN 10 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8/48 1948, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1948 to 1/8 1948 and that I last saw her alive on 1/8 1948

Immediate cause of death	Duration
CORONARY INSUFFICIENCY	
Due to MYOCARDIAL FIBROSIS	
Due to CORONARY ARTERIO-SCLEROSIS	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Myocardial Fibrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Sabatelly
Address West Balto. Gen. Hosp. Date signed 1/9/48

VS 150

X

G58893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN KATHERINE BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Harry H. Brown
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) June 4, 1878

8. AGE: Years	Months	Days	If less than one day
69	7	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Kreamer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schwartz
15 Birthplace Germany

16 (a) Informant Mr. Harry Brown
(b) Address 1413 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1948 at 7.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1945 to 1-9 1948. and that I last saw her alive on 1-8 1949.

Immediate cause of death	Duration
Cerebral Haemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. L. Ewell Jr. M.D.
Address 56 York Ct. Date signed 1-9-48

X

C58894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C58894

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey Street
(c) Hospital or institution: Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 N. Clinton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILHELMINA HENDRICKS

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles Hendricks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1865

8. AGE: Years	Months	Days	If less than one day
82	5	23	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Christian Koemp
13. Birthplace Germany

MOTHER
14. Maiden Name Eva ?
15 Birthplace Germany

16 (a) Informant Mrs. Arthur M. Tegeder
(b) Address 2 N. Clinton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery or crematory 1st. Evangelical
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION A

20. DATE OF DEATH January 9, 1948 8.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to Jan 9 1948 and that I last saw her alive on Jan 9 1948

Immediate cause of death	Duration
Cardiac Renal Disease	
Due to	
Due to	
Other Conditions Asphyxiation by Inhalation of Gas	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature THEO. KOLDEWEY Theo Koldewey M. D.
Address 27 N Carey Date signed 1/9/48

G58895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G58895

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 836 Glen Allen Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 836 Glen Allen Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johannah Gaa

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife late Louis Gaa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1869

8. AGE: Years	Months	Days	If less than one day
78	-	29	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Paul Eisinger
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs. Paul Gaa
(b) Address 836 Glen Allen Drive

17 (a) Burial (b) Date thereof 1-12-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey Md.

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave.

19 JAN 10 1948 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1948, at 7:13 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 to Jan 9 1948 and that I last saw h~~e~~ alive on Jan 8 1948

Immediate cause of death	Duration
Cardio-Vascular Renal Disease	3 mos.
Due to Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward J. Mulgan M.D. M.D.
Address 6 Washington Blvd Date signed Jan 10 48

Baltimore 30 Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58896 G58896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4213 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4213 Frederick Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Dr Paul R Leary

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Hallie V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8 1903

8. AGE: Years	Months	Days	If less than one day
45	-	-	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER
12. Name Roland F Leary
13. Birthplace Delaware

MOTHER
14. Maiden Name Annie Miller
15. Birthplace Penna

16 (a) Informant Mrs Paul R Leary
(b) Address 4213 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Elkridge Md

18 (a) Funeral director Fuge & Tilley
(b) Address Catonsville Md.

JAN 11 1948
(Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1948 at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 5 1948 to Jan. 8 1948, and that I last saw h-- alive on January 7 1948

Immediate cause of death	Duration
Hemorrhage from Esophageal Varices	1 da.
Due to Cirrhosis Liver	3 yr.
Due to	
Other Conditions Hypertension Arterio-sclerosis	5 yr.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin K. Gallagher M.D.
Address Catonsville, 25, Md Date signed 1/9/48

Written for Williams, M.D.

G58897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G58817

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Le
(c) Hospital or institution:
Home for the Aged Room 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Gray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	W.

6 (b) Name of husband or wife John Gray (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
92			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Butler
13. Birthplace

MOTHER
14. Maiden Name Sallie Smith
15. Birthplace

16 (a) Informant Sallie Smith 2 Ne Poe
(b) Address 1200 Valley Le.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St.

19 (a) JAN 7 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1948, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1947 to Jan 9 1948, and that I last saw h[illegible] alive on Jan 9 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Cerebral Arterio Sclerosis	3 yrs
Due to	
Other Conditions Diabetes Mellitus	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Av Date signed 1/10/48

97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58898

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 940

Registered No. G58898

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6892 Belclare Rd
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Belgium

3 (a) FULL NAME Evelyn Louise Cupp

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife William P. Cupp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/10/1906

8. AGE: Years 41 | Months 0 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation stenographer-operator
11. Industry or business

FATHER
12. Name George L. Moore
13. Birthplace Va.

MOTHER
14. Maiden Name Rose Probene
15. Birthplace Balto.

16 (a) Informant Mr. Wm. Cupp
(b) Address 6892 Belclare Rd

17 (a) Burial (b) Date thereof Jan 12, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oaklawn
Location Eastern Blvd.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk ave.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, MD

JAN 11 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9/48 19 , at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9-48 19 to 1/9/48 19 , and that I last saw h[illegible] alive on 1/9/48 19 .

Immediate cause of death Coronary occlusion
Due to Myocardial Infarction
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy coronary occlusion & myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Dutrow M.D.
Address Church Home & Hosp. Date signed 1/9/48

X

Dr. Sawyer 58899 BALTIMORE CITY HEALTH DEPARTMENT 6588 39
CERTIFICATE OF DEATH 1937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (K.) Catherine Kramer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Max T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 28-1873

8. AGE: Years	Months	Days	If less than one day
74	9	13	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER 12. Name Sigmond Junger
13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Kaufmann
15 Birthplace Wisconsin

16 (a) Informant Mr. K. N. Feldman
(b) Address 2505 Eue St. N.W.

17 (a) Burial (b) Date thereof 1-13-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto.

18 (a) Funeral director Leopold J. Leuck
(b) Address 5305 Harford Rd.

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 11 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1948, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1946 to Jan 10 1948, and that I last saw HER alive on Jan 3 1948.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	5 years
Due to Generalized Arteriosclerosis	8 years
Due to	
Other Conditions Bronchial asthma	3 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Sawyer M. D.
Address 4808 Harford Rd. Date signed 1/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G58900 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2620 E. Monument St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 6 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2620 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Missouri E. Abbott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife George Abbott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1879

8. AGE: Years 68 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name John Hayward
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Todd
15. Birthplace Maryland

16 (a) Informant Florence J. Hartman
(b) Address 2620 E. Monument St

17 (a) Removal (b) Date thereof Jan 13, 1948 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Church Creek, Md.
Location

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna. Ave., Balto.

19 (a) JAN 11 1948 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1948, at 10 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1947 to Jan 10 1948 and that I last saw her alive on Jan 8 1948

Immediate cause of death	Duration
Acute Cardiac Failure	1 day
Arteriosclerotic Heart	2 yrs
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Israel Rosen, M. D.
Address 2413 E Monument St

4/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

658901 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St
(c) Hospital or institution: Crawford retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 No Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Maleson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Isaac

13. Birthplace Poland

MOTHER 14. Maiden Name Hudza

15. Birthplace Poland

16 (a) Informant Leon Maleson

(b) Address 2126 No Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem

Location Windsor Mill Road

18 (a) Funeral director Jack Leeds Inc

(b) Address 2100 Eutaw Place

19 (a) JAN 12 1948 (Date rec'd by Registrar) (b) Thos. Jos. Williams, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11-1948, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1947 to 1/11 1948, and that I last saw h[illegible] alive on 1/[illegible] 1948.

Immediate cause of death: Cancer - Breast

Duration: 14 yrs.

Due to:

Due to:

Other Conditions: Metastasis - Brain - Lungs

Duration: 7

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph L. Pelaum

Address 1206 E. Baltimore St Date signed 1/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

658902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 N. Carlton
(c) Hospital or institution: 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 N. Carlton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Charlottesville Va.
(Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " " "

16 (a) Informant Louise Williams
(b) Address 1009 N. Carlton St

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Samuel W. Sulbrano Jr.
(b) Address 1011 N. Arlington Ave

19 (a) (Signature by registrar) Beatrice Fox Williams

JAN 13

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 19 48, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 19 47 to 1-8 19 48, and that I last saw h[illegible] alive on 1/4 19 48

Immediate cause of death

(a) Cardiovascular Renal Disease — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]

Address 1011 N. Arlington Ave. Date signed 1/13/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G58903 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 Caswell St
(c) Hospital or institution: 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Caswell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodora A. G. Fuchs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30 1879

8. AGE: Years 68 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Tyletts Church Brick Stone

11. Industry or business

FATHER
12. Name George A. Fuchs
13. Birthplace Balto Md

MOTHER
14. Maiden Name Ida A. Hockler
15. Birthplace Pittsburg Pa

16 (a) Informant Miss. Ruby A. Fuchs
(b) Address 1508 Caswell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12 1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md.

18 (a) Funeral director Francis Cook Sons
(b) Address 1600 W. North Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

JAN 11 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1948 at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1945 to 1/7 1948 and that I last saw h alive on 19

Immediate cause of death Mitral regurgitation — Duration years

Due to Carcinoma of stomach — Duration months

Due to — Duration days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Fuchs

Address 3902 Broadway Date signed 1/10/48 M. D.

G58904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58904

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Boonsboro Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Julia K. Smith
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 1/12/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~
Location Boonsboro Md

18 (a) Funeral director Wm F Bast + Son
(b) Address Boonsboro Md.

19 (a) JAN 12 1948 [illegible] Huntington Williams M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11 1948, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947, to 1/11 1948 and that I last saw h[illegible] alive on 1/10 1948

Immediate cause of death Coronary Occlusion
Due to Arteriosclerosis
Due to Parkinsonism

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1/11/48

VS 150

G58905 — BALTIMORE CITY HEALTH DEPARTMENT — G58905

CERTIFICATE OF DEATH 47a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Pomrose Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Thomas Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Leah Norris
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 11/1887

8. AGE: Years	Months	Days	If less than one day
60	2	0	..... hr. ..... min.

9. Birthplace St Marys County Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James J. Norris
13. Birthplace St. Marys County Md.

MOTHER
14. Maiden Name Georgianna Colbert
15. Birthplace St Marys County Md

16 (a) Informant Leah L. Norris
(b) Address 1907 Pomrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/48 (month) (day) (year)
(c) Cemetery or crematory Maronda Memorial Park
Location Hughesville Md

18 (a) Funeral director Wilson & Ford
(b) Address 1210 Cont Ave

19 JAN 12 1948 (Date filed by registrar) (b) Transcribed for Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1948, at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1948 to 1-11 1948 and that I last saw him alive on Jan 11 1948

Immediate cause of death	Duration
Pulmonary hemorrhage	5 hrs
Due to Rupture of metastatic vessel	"
Due to Carcinoma larynx	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1947
Major findings of operation: Ca. laryngis & pulm. metastasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B Buechner M.D.
Address Mercy Hosp Date signed 1-11-48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55 B

Registered No. 658906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave.
(c) Hospital or institution:
St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Curtis Bay P.O. Route 2 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Airy Belle Giles.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband ~~or wife~~ William Giles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1890

8. AGE: Years 57 | Months 6 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. C. Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business Own Home

FATHER 12. Name James Bambey (died

13. Birthplace Md.

MOTHER 14. Maiden Name (Desmond) Tamie Harper

15. Birthplace Md.

16 (a) Informant William Giles

(b) Address Orchard Beach P.O. C. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)

(c) Cemetery or crematory Poplar

Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9- 1948, at 10 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 1948 to 1/9 1948, and that I last saw her alive on 1/9 1948.

Immediate cause of death	Duration
Osteogenic sarcoma of Skull with	7
Due to Metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy Osteogenic sarcoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert J. Lincke

Address St Agnes Hosp Date signed 1/10/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

658907 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd
(c) Hospital or institution: 27-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4702 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Bosworth

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Kurz
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Elsie Snyder
(b) Address 4702 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8th 1948 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 June 1947 to 8 Jan 1948, and that I last saw h[illegible] alive on 5 Jan 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerotic Cardio Vascular Disease	June 1947
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos W. Edmunds M. D.
Address 7746 Rue Alameda Date signed 9 Jan-48

VS 150

G58908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G58908 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 244
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State India (b) County
(c) City or town Calcutta
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country India

3 (a) FULL NAME Belat Hossein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Hindu

6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 55 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace India (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business S. Sq Alpha Mooi

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant British Vice Consulate
(b) Address Gillett Building

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) ~~Huntington~~ Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1948, at 4:55 P.M.

21. I certify that I took charge of the remains described above, held an Insp. ~~& Inquiry~~ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio vascular disease

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 1-9-48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58909

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1827 W. Pratt St
(c) Hospital or institution: 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Myrtle E. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: Edward L. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 1891

8. AGE: Years 56 | Months 9 | Days 5 | If less than one day: hr. min.

9. Birthplace Keefertown Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Edward Corey
13. Birthplace Kent Co. Md.

MOTHER
14. Maiden Name Anna (Unknown)
15. Birthplace Kent Co. Md.

16 (a) Informant Helen E. Perry
(b) Address 1844 W. Pratt st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JAN 12 1948 (Date received by registrar) (b) Theodore [illegible] Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9th 1948, at 6 10 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1948 to Jan 9 1948, and that I last saw her alive on Jan 8 1948.

Immediate cause of death: Osteosclerotic myocarditis — Duration: 7

Due to: Generalized arteriosclerosis — Duration: 2

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. B. Schreiber M. D.
Address 5-4 S. Fulton Ave Date signed 1-10-48

G58910

BALTIMORE CITY HEALTH DEPARTMENT

BC-48-00724 CERTIFICATE OF DEATH 160c

Registered No. G58910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-8
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 5611 Clearspring Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD - MARSHALL - MEYER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 48

8. AGE: Years	Months	Days	If less than one day
0	0	1/2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name George Bryan Meyer
13. Birthplace Kennerstown Ohio

MOTHER
14. Maiden Name Ruth Alice Hess
15. Birthplace Saltsburg Pa

16 (a) Informant mother
(b) Address 5611 Clearspring Rd

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-5-48 (month) (day) (year)
(c) Cemetery or crematory
Location Union Memorial

18 (a) Funeral director
(b) Address

19 (a) JAN 12 1948 (b) [illegible] for William [illegible]
(Signature of city registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1948, at 10 39 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 3 1948 to Jan 7 1948, and that I last saw alive on Jan 4 1948

Immediate cause of death	Duration
Atelectasis	
Due to premature birth	
Due to Caesarean Section for premature separation of	
Other Conditions Postmature Ogen 34 weeks	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Atelectasis Both Lungs

PHYSICIAN
Underline the cause to which death should be assigned statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Union Memorial Hosp Date signed 1/8/48 M.D.

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

058911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Register No. 058911

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5401 Gerland Ave
(c) Hospital or institution: 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5401 Gerland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Gertrude H. Shaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Jesse C. Shaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1890

8. AGE: Years	Months	Days	If less than one day
57	6	17	hr. min.

9. Birthplace Durlock Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Henry
13. Birthplace —

MOTHER
14. Maiden Name Mary Battle
15. Birthplace Durlock, Md.

16 (a) Informant Mr. Jesse C. Shaw
(b) Address 5401 Gerland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Taylor Ave

18 (a) Funeral director Howard N. Bright, Jr.
(b) Address 6009 Harford Road

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1948, at 5 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1947, to 1-9 1948, and that I last saw h[illegible] alive on 1-9 1948.

Immediate cause of death	Duration
Generalized Carcinomatosis	
Due to Carcinoma of Ovary	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6-14-48
Major findings of operation: Carcinoma Ovary & Uterus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1-9-48

058912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 058912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Frankford Ave.
(c) Hospital or institution: 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Frankford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN W. RUTLEDGE

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-5887

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Caroline Rutledge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1886

8. AGE: Years	Months	Days	If less than one day
61	4	14 15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Revere Copper & Brass Co

FATHER: 12. Name John W. Rutledge
13. Birthplace Balto., Md.

MOTHER: 14. Maiden Name Mary A. Roberts
15. Birthplace Balto., Md.

16 (a) Informant Mrs. J. W. Rutledge
(b) Address 3725 Frankford Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Jan. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Balto., Md.

18 (a) Funeral director Lannahan Funeral Home
(b) Address 7401 Belair Road

19 (a) 1-9-1948 (b) (Signature of registrar) Edith Lee Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1948 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1947 to Jan 10 1948, and that I last saw him alive on Jan 7 1948.

Immediate cause of death	Duration
Acute pulmonary edema	1 day
Due to Chr. myocardial disease	3 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A Lee Strahan
Address 4116 Northern Pkwy Date signed 1/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58913 GM. 116333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1192

Registered No. G58913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 Chestnut St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No) If yes, name country .....

3 (a) FULL NAME David Lee Barnett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 24 - 1947

8. AGE: Years	Months	Days	If less than one day
	6	16	..... hr. ..... min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

MOTHER, FATHER
12. Name Charles Barnett
13. Birthplace N.C.
14. Maiden Name Clara Bell Edwards
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) Filed JAN 12 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10-48 1948 at 7-55A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 - 1948, to 1 - 10 - 1948, and that I last saw him alive on Jan. 10 - 1948

Immediate cause of death	Duration
Encephalitis	2 days
Due to Diarrhea (viral?)	1 wk prev 2 days
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy Encephalitis - Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Julian P. Griffin M. D.
Address Balt. City Hospitals Date signed Jan. 11, '48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 658914

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 410 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel R. Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ethel Coleman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1875

8. AGE: Years 72 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business Self-employed

FATHER 12. Name John Wesley Coleman

13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Elizabeth Johns

15. Birthplace Calvert Co., Md.

16 (a) Informant Mrs. Clifton Coleman

(b) Address 514 Moore Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore, Md.

18 (a) Funeral director Charles R. Law

(b) Address 802 Madison Ave

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Jan. 1948 at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Wm. H. Kammerer M.D. Medical Examiner.

Date signed 10 Jan. 1948

VS 181

G58915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓166

Registered No. G58915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital | 7-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 667 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN Walter REED (John Walter Reed)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-9711

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced? Married

6 (b) Name of husband or wife Mary J. H. Reed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1889

8. AGE: Years 58 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Wafers Catering Co.

FATHER
12. Name John Reed
13. Birthplace Va

MOTHER
14. Maiden Name Catherine Whiting
15. Birthplace Va

16 (a) Informant Mary J. H. Reed
(b) Address 667 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14, 1948 (month) (day) (year)

(c) Cemetery or crematory
Location Valentine, Va.

18 (a) Funeral director John M. Johnson
(b) Address 1706 Druid Hill Ave

19 (a) JAN 12 1948 (Registered by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9, 1948, at 3.55 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized Peritonitis

Due to Gunshot wound of abdomen

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-5-48 at 10 P M. 667 W. Franklin Street.
(b) Where did injury occur? Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Earle V. Ruzicka M.D.
Medical Examiner.
Date signed 1-9-48

TEARS WHEN FILLED, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

658916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 658916

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Pylesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
*(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Hood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Mrs. Harry C. Hood
6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) 7/16/869

8. AGE: Years	Months	Days	If less than one day
78	5	24	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Hood
13. Birthplace Maryland

MOTHER
14. Maiden Name Alverta McAllister
15. Birthplace Maryland

16 (a) Informant Mrs. Harry C. Hood
(b) Address Pylesville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany. 13/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) JAN 12 1948 (Date received by Registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1948 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1947 to Jan 10 1948 and that I last saw him alive on Jan. 10 1948

Immediate cause of death: empyema of chest, right — Duration: 5 days

Due to: Post-operative pneumonia

Due to:

Other Conditions: Carcinoma of the cecal area.
(Include pregnancy within 3 months of death)

Date of operation 12-5-47

Major findings of operation: Carcinoma

Carcinoma of the cecal region

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watkins M.D.
Address Union Memorial Hosp. Date signed 1/10/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 658917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden + Madison Ave.
(c) Hospital or institution:
Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 68
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hanover Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Rose Lanham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Edward Earl Lanham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1894

8. AGE: Years 54 | Months | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Balto Co.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alfred Bosley
13. Birthplace Balto Co.

MOTHER
14. Maiden Name Louise Coates
15. Birthplace Balto Co.

16 (a) Informant Edward Earl Lanham
(b) Address Reisterstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto Co

18 (a) Funeral director J. F. Reni Sons
(b) Address Reisterstown Md

19 (a) JAN 12 1948 (Rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 1948, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1947 to 1/12 1948 and that I last saw h[illegible] alive on 1/12 1948

Immediate cause of death cardiac failure + terminal pneumonia

Due to subarachnoid hemorrhage 1 general debility

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Johan L Miller M. D.
Address Maryland Gen. Hosp. Date signed 1/14/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G58918

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 167
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 WINCHESTER ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARL Clemmie DRAFTS

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 705-10-4025

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Amy Gertrude Drafts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 5, 1886

8. AGE: Years 61 | Months 9 7 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B. & O. R. R.

FATHER
12. Name Thomas P. Drafts
13. Birthplace South Carolina

MOTHER
14. Maiden Name Sarah Drafts
15. Birthplace South Carolina

16 (a) Informant Miss Florence M. Drafts, daughter
(b) Address 2911 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Jan 12 1948 (b) Huntington Williams, MD
Registered by (Local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1948 at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Dec 1947 to 9 JAN 1948 and that I last saw HIM alive on 9 JAN 1948

Immediate cause of death: UREMIA - ACIDOSIS — Duration:
Due to Nephrosclerosis
Due to Hypertensive CV-RENAL DISEASE
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: SAME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Matcher
Address WBGH Date signed Jan 9

X 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G58919

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322- Linden Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Berg

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 086-16-9260

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Kirsti Berg
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Feb. 17-1881
8. AGE: Years 66 | Months 10 | Days 19 | If less than one day hr. min.
9. Birthplace: Roros, Norway (Town, county and state)
10. Usual Occupation: Coast Guard Retired
11. Industry or business

FATHER
12. Name: Kjosten Berg
13. Birthplace: Norway

MOTHER
14. Maiden Name: Jacobine Tendberg
15. Birthplace: Norway

16 (a) Informant: Mrs. Agnes Tveitnak
(b) Address: 1602 Briscoe Road, Charleston, S.C.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12-1948 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Baltimore, Maryland
18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3631 Falls Road
19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1948 at 6.40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypostatic Pneumonia C.J. Dreme

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Ryan M.D. (Medical Examiner)
Date signed 1-7-48

VS 181

658920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

658920 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette + 33rd Sts
(c) Hospital or institution: Mercy Meem. Hosp 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Hawthorne Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME CLARENCE HERBERT CLAYTON

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-07-6301

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	M	Lillian E. Clayton M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26-1877

8. AGE: Years	Months	Days	If less than one day
70	2	15	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business U.S. Fed. Govt.

FATHER
12. Name William E. Clayton
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Williamson
15. Birthplace Maryland

16 (a) Informant Mrs. Lillian E. Clayton
(b) Address 210 Hawthorne Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14 1948 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Maryland

18 (a) Funeral director Burgie Funeral Home
(b) Address 3621 Falls Road

19 (a) 1-12-1948 Hunter for Williams M.D. (Date received) (By registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 11 1948 at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1948, to Jan 11 1948, and that I last saw him alive on JAN 11 1948

Immediate cause of death: Ruptured Aneurysm of Aorta — Duration: 1 day
Due to Arteriosclerosis.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy Exclusive

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address Date signed 1-14-48

Verified HOWARD J. MALDEIS, M.D. Per: [signature] M.D.

G58921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G58921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 839 Harlem Ave
(c) Hospital or institution: 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 839 Harlem Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MAGGIE WINSTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/1901

8. AGE: Years	Months	Days	If less than one day
46	10	24	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name James Winston
13. Birthplace

MOTHER
14. Maiden Name Martha Jones
15 Birthplace

16 (a) Informant Ida Mae Chappell (C)
(b) Address 839 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 JAN 12 1948 Huntington Williams M.D. (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8/48 19 at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1948 to Jan 8 1948, and that I last saw him alive on Jan 3 1948.

Immediate cause of death	Duration
(a) Coronary Thrombosis	5 dy
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Wall M. D.
Address 861 Harlem Ave Date signed 1-12-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C58922

1. PLACE OF DEATH: Levendale Home
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave & Greenspring Ave
(c) Hospital or institution: 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GOLDIE SHAPIRO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: None

FATHER
12. Name: Louis Posner
13. Birthplace: Russia

MOTHER
14. Maiden Name: Unkown
15. Birthplace: Russia

16 (a) Informant: Mrs Maurice Goldstone
(b) Address: 3919 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12, 1948 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) (Date) Jan 12 1948 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1948 at 12 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1947 to 1-11 1948 and that I last saw h alive on 1-11 1948

Immediate cause of death: Chron'c cardi'o-vascular disease — Duration

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Date signed 1-11-48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

Registered No. 658923

CM. 94454

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals. 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 569 Lawrence ST.
LAURENS (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Laura (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July - 3 1871

8. AGE: Years	Months	Days	If less than one day
76	6	8	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation Gardner
11. Industry or business

FATHER
12. Name Hilway Mason (D)
13. Birthplace MD.

MOTHER
14. Maiden Name Janie Young (D)
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-1948 (month) (day) (year)
(c) Cemetery or crematory Bethany Palms, Inc.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Lud. J. Hallman
(b) Address 6651 Reisterstown Rd.

19 (a) JAN 12 1948 (Registered by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 - 1948 at 1.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 - 30 - 1945 to Jan. 11 1948 and that I last saw h. im alive on Jan. 11 - 1948

Immediate cause of death — Duration

Benign Nephrosclerosis Chronic
Due to Hypertension and Cardiovasc. Disease 2 yrs
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. R. Dearborn M. D.
Address Balto City Hosp. Date signed 1-11-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 853a

Registered No. 658924

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 Division St
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elenora Kellum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Colored	Married

6 (b) Name of husband or wife Ethel C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-3-1894

8. AGE: Years	Months	Days	If less than one day
53	1	5	hr. min.

9. Birthplace Accomac Co. Va (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name George Kellum

13. Birthplace Accomac Co. Va

MOTHER 14. Maiden Name Anderson

15. Birthplace

16 (a) Informant Mrs. Ethel C. Kellum

(b) Address 1117 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12, 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co.

18 (a) Funeral director Mrs. Geo. F. Holland

(b) Address 1621 Druid Hill Ave

19 (a) 1-12-1948 (Date received by registrar) (b) Function for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1947 to 1-8 1948 and that I last saw h.i.M alive on 1-8 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.

Address 53-4 Dolfield Date signed 1-10-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. 658925

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 Mount Olivet Lane.
(c) Hospital or institution: 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Mount Olivet Lane. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma C. Montgomery - Wilson.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed.

6 (b) Name of husband or wife Wm. Wilson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-18-1863

8. AGE: Years	Months	Days	If less than one day
84	7	21/23	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation Retired Matron.
11. Industry or business Gas & Electric Co.
FATHER 12. Name George Hasehest.
13. Birthplace Germany.
MOTHER 14. Maiden Name Unknown.
15. Birthplace Germany
16 (a) Informant Mrs. Andrew Schmidt.
(b) Address 232 Mt. Olivet Lane.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12 (month) (day) 48. (year)
(c) Cemetery or crematory Loudon Park Cem. City.
Location
18 (a) Funeral director Charles J. Schumb.
(b) Address 3512 Frederick Ave.
19 (a) (Date received by Registrar) (b) Huntington Williams (Registrar)
JAN 12 1948
V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9th, 1948, at 8 A. M.
21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to 1/9 1948 and that I last saw h[illegible] alive on Jan 9 1948.

Immediate cause of death	Duration
Hypostatic Pneumonia	10 days
Due to Senile Cardio-Vascular Disease & Hypertension	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Eliot W. Johnson M. D.
Address 8432 Frederick Ave. Date signed

G58926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registered No. X G58926

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days)? 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County a a.
(c) City or town [redacted] Curtis Corner
(If outside city or town limits, write RURAL and give town)
(d) Street No. Arnold Md
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Higgs

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Wid

6 (b) Name of husband or wife Bernard Higgs
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 11-3-47

8. AGE: Years	Months	Days	If less than one day
	2	6	hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Wid

FATHER
12. Name Bernard Higgs
13. Birthplace Md

MOTHER
14. Maiden Name Amelia Hickey
15. Birthplace Md

16 (a) Informant Amelia Higgs
(b) Address Curtis Bay, Baltimore, Md

17 (a) Burial (b) Date thereof 1-14-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md

18 (a) Funeral director T. C. Higginbotham
(b) Address Ellicott City Md

19 (a) JAN 12 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1948 at 10:42 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1948 to 1-11 1948.
and that I last saw h.e.y. alive on 1-11 1948.

Immediate cause of death	Duration
Marasmus	6 days
Due to Malnutrition	3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Carcinoma Uterus Ca. Cervix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Mercy Date signed 1-12-48 M. D.

658927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 658927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1026 N. Wolfe St
(c) Hospital or institution: 7-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Threat

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20, 1896

8. AGE: Years: 52 | Months: 3 | Days: 18 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James Threat
13. Birthplace Va

MOTHER 14. Maiden Name Annie Lane
15. Birthplace Va.

16 (a) Informant Annie Threat
(b) Address 2609 Dupont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9 48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Old County Rd

18 (a) Funeral director McDott & Ellwood
(b) Address 1129 N. Carlton St

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1948; at 1:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 - 48 to Jan 5 - 48 and that I last saw him alive on Jan 4 - 1948

Immediate cause of death: Coronary Occlusion — Duration: 4 days

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Murphy M.D.
Address 1129 N. Carlton St Date signed Jan 9 48

G58928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V. 13 B

Registered No. G58928

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 959 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Beulah Walton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-29

8. AGE: Years 18 | Months 17 | Days 3 | If less than one day hr. min. 19

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER 12. Name Willie Walton
13. Birthplace Va

MOTHER 14. Maiden Name Pearl Carter
15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12 48 (month) (day) (year)
(c) Cemetery or crematory
Location Millerville Va

18 (a) Funeral director Mrs Pott & Ellis Sons
(b) Address 1129 N. Caroline St

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Signature for Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1948, at 4 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1947 to Jan 9 1948 and that I last saw h[illegible] alive on Jan 9 1948

	Duration
Immediate cause of death: tuberculous meningitis	7 days
Due to: disseminated tuberculosis	6 mos.
Due to:	
Other Conditions: pelvic Tbc, pelvic abscess, uremia	

(Include pregnancy within 3 months of death)

Date of operation 10/22/47
Major findings of operation: abdominal abscess
of autopsy: disseminated tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dale D. Foster M. D.
Address Johns Hopkins Hosp. Baltimore Date signed 1/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

658929 Registered No. 658929

658929

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 Baker St
(c) Hospital or institution: 521
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Baker ST (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Downs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Celeste Downs

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE Years 76 | Months — | Days — | If less than one day hr. min.

9. Birthplace Fairfield Md. (Town, county, and state)

10. Usual Occupation General Housework

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Celeste Downs
(b) Address 602 Baker St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-12-48 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Geo. G. Colton
(b) Address 1383 Freestman St

19 (a) 1-9-1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1948; at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947, to Jan 9 1948, and that I last saw him alive on Jan 9 1948.

Immediate cause of death	Duration
Acute coronary sclerosis	Month
Due to Hypertrophy & Dilatation of Left	10 yrs.
Due to Criteria sclerosis	—
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno. N. Penn Slater M. D.
Address 1723 Druid Hill Ave Date signed Jan 9 1948

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G58930
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28-4
(c) Hospital or institution: Mercy Hospital - D. O. A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 Mallow Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl E. Humphreys

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Maude E. (Legg)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1901

8. AGE: Years	Months	Days	If less than one day
46 45	5	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Balto. City Fire Dept.

FATHER
12. Name Charles
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida B Rush
15. Birthplace Maryland

16 (a) Informant Maude E Humphreys
(b) Address 20 Mallow Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location 2930 Fredenick Ave

18 (a) Funeral director Harry H Wilhelm
(b) Address 411 Edmondson Ave

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Burington Williams Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11 1948, at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute congestive heart failure
due to arteriosclerotic cardiovascular
Due to ulcer disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 1/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G58931
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 E. 31st. Street
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 E. 31st. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE OVERBECK

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Theodore Overbeck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1868

8. AGE: Years 79 | Months 7 | Days 22 | If less than one day ....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Graf
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Seebach
15 Birthplace Germany

16 (a) Informant Miss Catherine Overbeck
(b) Address 1900 E. 31st. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 12 1948 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1948 2.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Jan 10 1948 and that I last saw him alive on Jan 9 1948

	Duration
Immediate cause of death: Bronchial Pneumonia	9 days
Due to: Senile Condition	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. E. Kuyer M. D.
Address Western Cemetery (Physician) 1/10/48

G58932 Pierce

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G58932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hosp 7-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 841 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mathew J. Pierce

3 (b) If veteran, name war

3 (c) Social Security Account No. 52 [illegible] 440

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/20/1893

8. AGE: Years	Months	Days	If less than one day
54	11	29	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Tavern Keeper

11. Industry or business

FATHER
12. Name John Pierce
13. Birthplace Bohemia

MOTHER
14. Maiden Name Josephine Satt
15. Birthplace Bohemia

16 (a) Informant Josephine Pierce
(b) Address 841 N Collington Ave.

17 (a) Burial (b) Date thereof 1-13-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Brachdor
(b) Address 900 N. Chester St

19 (a) (b)
(Date received by registrar) Registrar

JAN 12 1948
V S 150

Cottington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1948, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1948 to 1/10 1948 and that I last saw him alive on 1/10 1948.

Immediate cause of death	Duration
Portal cirrhosis with bleeding	
Due to esophageal varices	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert E May
Address 1400 N Caroline St Date signed 1/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G58933
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 WILLIAM ST
(c) Hospital or institution: 24.3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No 1132 WILLIAM ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HART.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife MARY HART.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) FEB-20 1865

8. AGE: Years	Months	Days	If less than one day
82 81	10	10 19	hr. min.

9. Birthplace GERMANY. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name ADAM HART.
13. Birthplace GERMANY.

MOTHER
14. Maiden Name NOT KNOWN
15 Birthplace GERMANY

16 (a) Informant MRS MARIE APPEL
(b) Address 1214 BATTERY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 13-48 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location A.A.Co.

18 (a) Funeral director Bernard E. Harle
(b) Address 121 E Mad St
(c) JAN 12 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 9th 1948 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1947 to 1/9 1948, and that I last saw h[illegible] alive on 1/8 1948

Immediate cause of death	Duration
— Uremic Coma	1 day
Due to — Chronic Nephritis	6 mos
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. W. Mettee M. D.
Address 1279 William Date signed 1/9/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

~~658934~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (Towson) (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~365~~ 369 Hillen Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-6724

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Angelina Williams

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 8. 1890

8. AGE: Years	Months	Days	If less than one day
57	6	1	____hr. ____min.

9. Birthplace Towson, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alex Williams
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Lizzie Brierley
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs Angeline Williams
(b) Address 369 Hillen Rd. Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 / 13 / 48 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest.
Location Towson Md.

18 (a) Funeral director William D. Chatman Jr
(b) Address 120 McCulloh St.

JAN 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1948 at 12 Noon PM

21. I certify that I took charge of the remains described above, held an Inqs. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl H. Reyer M.D. Medical Examiner.
Date signed 1-10-48

658935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 658935

GM. 1116490

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Essex-Baltimore Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Miles RD. Middle Boro Box 248
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Eleanor Quillin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 - 1896

8. AGE: Years	Months	Days	If less than one day
51	5	23	hr. min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Phillips
13. Birthplace MD.

MOTHER
14. Maiden Name Mary ?
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1-14-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Haven
Location Balto Co.

18 (a) Funeral director M. Brundage
(b) Address 1466 Eastern Ave Rd

19 JAN 12 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 11 - 1948, at 5.55A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 10 1948 to 1 - 11 - 1948 and that I last saw her alive on 1 - 11 - 1948

Immediate cause of death Cerebral Hemorrhage

Due to Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. A. Lamborn M.D.
Address Balto City Hosp. Date signed 1-11-48

VS 150

G58936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G58936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 S. Macon St.
(c) Hospital or institution: 267
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 S. Macon St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John Bieger, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Moerschel

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1887

8. AGE: Years 60 | Months 4 | Days 22 23 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Bieger
13. Birthplace Unknown

MOTHER
14. Maiden Name Bertha ?
15 Birthplace ?

16 (a) Informant Theodore Bieger
(b) Address 10 Barrison Pt. Rd. Rt.13(21)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Gwynnbrook Road

18 (a) Funeral directors Lilly & Zeiler Inc.
(b) Address 403 South Wolfe St

19 (a) Jan 12 1948 (Date filed by Registrar) (b) Huntington for Williams, Jr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9, 1948, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/ /1947 to 1/9/1948 and that I last saw h[illegible] alive on 1/9/1948

Immediate cause of death	Duration
Carcinoma of Liver,	
Due to Cirrhosis of Liver.	
Due to	
Other Conditions General arteriosclerosis.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. M. Eberhart M.D.
Address [illegible] Date signed 1/13/48

X

6588937

BALTIMORE CITY HEALTH DEPARTMENT ✓ X Registered No. 6588937

CERTIFICATE OF DEATH 830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.,
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Belmar Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Estella Smith

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Winfield N. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1880

8. AGE: Years	Months	Days	If less than one day
67	9	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Geo ge W.A. Meyer
13. Birthplace

MOTHER
14. Maiden Name Catherine O. Peacock
15. Birthplace

16 (a) Informant Mossison Smith
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/ 13/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1948 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1947 to Jan 9 1948 and that I last saw h.. alive on Jan 9 1948

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days
Due to Arteriosclerosis
Due to Hypertension.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl H. Zeusar, M.D.
Address 5111 York Rd Date signed 1/10/48 M. D.

VS 150

D 558938

BALTIMORE CITY HEALTH DEPARTMENT ✓X

CERTIFICATE OF DEATH - 46E

Registered No. 558938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Chu. Broadway
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13d.
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 58 Admiral Blvd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Clyde Ellis Taber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Bonnie Nona Taber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1895

8. AGE: Years 52 | Months 11 10 | Days 23 7 | If less than one day ..... hr. ..... min.

9. Birthplace Davis West Virginia (Town, county, and state)

10. Usual Occupation Mechanical Engineer

11. Industry or business

FATHER
12. Name Jude Faber
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Cora Harr
15. Birthplace Davis West Virginia

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balt Co Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 1308 Pocahontas Ave, Balto

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1948 at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1947 to 1-10 1948 and that I last saw him alive on 1-10 1948

	Duration
Immediate cause of death: Hemorrhage into G.I. Tract (Ileum)	Terminal
Due to: Adeno carcinoma of Colon (Descending & Sigmoid)	18 mos
Due to:	
Other Conditions: Metastases to Ileum Peritoneum, Liver. (Include pregnancy within 3 months of death)	

Date of operation 9-19-47

Major findings of operation: Adeno Carcinoma of Colon

of autopsy: Extensive Carcinoma Peritoneum

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry B. Wilson M. D.
Address Church Home Hosp. Date signed 1-11-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58939
JL - 116453

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C58939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 1-3
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 733 N. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Kammerer

3 (b) If veteran, name war
3 (c) Social Security Account No. 216-05-3158

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1888

8. AGE: Years	Months	Days	If less than one day
59	8	25	hr. min.

9. Birthplace XX Baltimore, Md. (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name ? William Frederick Kammerer
13. Birthplace ? Germany

MOTHER
14. Maiden Name ? Barbara Bonza
15. Birthplace ? Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)
(c) Cemetery or ~~XXXXXX~~ Holy Redeemer
Location 4430 Belair Road. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-3-5 E. Madison St.

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1948, at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1948 to Jan. 11 1948, and that I last saw h[illegible] alive on Jan. 11 1948.

Immediate cause of death	Duration
Cerebral thrombosis	
Due to Arteriosclerosis	
Due to	
Other conditions Uremia; Bronchopneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. K. Shaffhausen M. D.
Address Balto City Hosp Date signed 1-11-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 658940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8.4
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 E Oliver St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James Rogers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1871

8. AGE: Years 77 | Months | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Thynsen
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Fitzpatrick
15. Birthplace Md.

16 (a) Informant Mrs Marie V. Brown
(b) Address 2314 E Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Frederick Road

18 (a) Funeral director John C. Miller Jr
(b) Address 2435 E Oliver St

19 JAN 12 1948 Date rec'd by Registrar Huntington Williams Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11/48 19..., at 6:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 19 48 to 1/11 19 48
and that I last saw h[illegible] alive on 1/11 19 48

Immediate cause of death: Cardiac failure — Duration

Due to: Carcinoma of Stomach

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R B Scott M. D.
Address Mercy Hospital signed 1/11/48

X

G58941 BALTIMORE CITY HEALTH DEPARTMENT G58941
Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 St. Joseph's Hosp
(c) Hospital or institution: 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2347 Chesterfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick A. Sturgeon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude M. Sturgeon
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) January 4 1888

8. AGE: Years 59 | Months | Days 7 | If less than one day hr. min.

9. Birthplace Chicago Ill. (Town, county, and state)

10. Usual Occupation
11. Industry or business Balto. Police Dept

FATHER 12. Name Charles A. Sturgeon
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Lena Bonaker
15. Birthplace Balto. Md.

16 (a) Informant Gertrude M. Sturgeon
(b) Address 2347 Chesterfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Cem.
Location Taylor Ave

18 (a) Funeral director John E. Mellstrom
(b) Address 2435 E. Oliver St

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Jan. 1948, at 9:15 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kramer Jr. M.D. Medical Examiner.
Date signed 11 Jan. 48

VS 131

058942 SC-C 95486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 058932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City Baltimore
(c) City or town Lauraen P
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1663 Yakoma Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Robert Dunning Robert Norman Dunning

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife
6 (c) If alive, give age years.

7. Birth date of deceased (mo., day, yr.) 11-29-47

8. AGE: Years 0 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Mercy Balto Md (town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name C. Burton Dunning
13. Birthplace Md (Balto)

MOTHER 14. Maiden Name Jane Bowerman
15. Birthplace Md (Balto)

16 (a) Informant Mrs. Jane B. Dunning
(b) Address 1663 Yakoma Rd (14)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-48. (month) (day) (year)
(c) Cemetery or crematory Druid Hill
Location Lauraen

18 (a) Funeral director Stewart & Mowen Co
(b) Address 108 W. Northern. City #1

19 (a) 1-12 1948 (b) Huntington Williams
(Date received by Registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13 1948, at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1948 to 1-13 1948 and that I last saw h[illegible] alive on 1-13 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to Congenital Heart	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Path
Lesion & Cause
of autopsy: Hypothesis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm R Bond M. D.
Address Mercy Date signed 1-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R58943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered R58943

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4218 Kennison Ave
(c) Hospital or institution: 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4218 Kennison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Agnes Corrigan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1 1877

8. AGE: Years 70 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Patrick Corrigan
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Brady
15. Birthplace Baltimore Md

16 (a) Informant Harry M. Corrigan
(b) Address 4218 Kennison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry H. Limacod
(b) Address 4204 Ridgewood Ave

19 (a) JAN 12 1948 (Date rec'd by registrar) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12, 1948, at 4 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from on Jan 12 1948 to 19, and that I last saw her alive on Jan 12 1948.

Immediate cause of death	Duration
Congestive Heart Failure	4 hours
Due to Arterio-Sclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James C. Black M. D.
Address 535 E Baltimore Blvd Date signed 1/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G58944

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 Jackson Street
(c) Hospital or institution: 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Jackson St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Robert F. Murphy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mamie L. Murphy (nee Selby)

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 26, 1869

8. AGE: Years 78 | Months 9 | Days 14 | If less than one day: hr. ½ min.

9. Birthplace Muirkirk, Prince George Co., Md. (Town, county, and state)

10. Usual Occupation Retired B. & O. R. R.

11. Industry or business Engineer

FATHER
12. Name William Thomas Murphy
13. Birthplace Montgomery Co., Md.

MOTHER
14. Maiden Name Mary Elizabeth Hopkins
15. Birthplace Prince George Co., Md.

16 (a) Informant Mrs. Laura E. Seymour
(b) Address 1512 Jackson St. (Daughter)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Springfield Cemetery
Location Sykesville, Carroll Co., Md.

18 (a) Funeral director C. Howard Evans
(b) Address 1500 S. Charles St. Balto 30, Md.

19 JAN 12 1948 (Date rec'd by registrar) (b) Permit issued for Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10, 1948 at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1947 to 1-10 1948
and that I last saw him alive on 1-10 1948

Immediate cause of death: Chronic Myocardial Degeneration — Duration 2 yrs.
Due to Arteriosclerosis — 5 yrs.
Due to —
Other Conditions Chronic Nephritis — 2 yrs.

— (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature A. A. Sellers M. D.
Address 207 E. Fort Ave. Date signed 1-12-48

VS 150

927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

058945

BC - 029857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

Registered No. 058945

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 1102 E.Hoffman Street
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days): None
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: City
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1102 E.Hoffman Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Richard P.Darr

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 8th.,1945

8. AGE: Years: 2 | Months: 5 | Days: 4 | If less than one day: ########## min.

9. Birthplace: Baltimore,Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER:
12. Name: Raymond E.Darr
13. Birthplace: ########## Virginia

MOTHER:
14. Maiden Name: Margaret G.Douglas
15. Birthplace: Baltimore,Md.

16 (a) Informant: Raymond E.Darr (Father)
(b) Address: 1102 E.Hoffman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/14/48 (month) (day) (year)
(c) Cemetery or crematory: St. Mathai
Location: 6104 O'Donnell Street

18 (a) Funeral director: George J.Ruth,Inc.
(b) Address: 1735 Harford Avenue,Balto:Md.

19 JAN 12 1948 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 Jan 1948, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Jan 1948 to 12 Jan 1948, and that I last saw h[illegible] alive on 11 Jan 1948

	Duration
Immediate cause of death: pneumonia	2
Due to: aspiration due to vomiting	less than one day
Due to: Upper respiratory infection	2 days
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Samuel Silverfield M. D.
Address: 714 E. Preston Date signed: 12 Jan 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

658946 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville Ave
(c) Hospital or institution: Jewish Memorial 27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2920 Glenmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Michael Elder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Mary Calahan
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1869

8. AGE: Years	Months	Days	If less than one day: hr.	min.
78	3	29		

9. Birthplace Maryland (town, county and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER
12. Name Richard Elder
13. Birthplace Germany

MOTHER
14. Maiden Name Monica Miles
15. Birthplace Germany

16 (a) Informant Mrs. Wm. J. Elder
(b) Address 1703 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director L. J. Lock
(b) Address 5305 Harford Rd.

19 (a) [illegible] (b) Thomas J. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1948 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to 1/10 1948 and that I last saw h[illegible] alive on 1/7 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Murtagh M.D.
Address 5 Chase Date signed 1/11/48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B

Registered No. 658947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd St.
(c) Hospital or institution: Union Memorial Hospital 15-B
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4129 Bob Hope Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mr. Leo Aloysius Bagwell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Rosaline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27-1879

8. AGE: Years 68 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Textile worker

11. Industry or business Wm. E. Hooper Mill

FATHER
12. Name John W. Bagwell
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Mary A. Connelly
15. Birthplace Balto. Md.

16 (a) Informant Raphael V. Bagwell
(b) Address 334 Rossiter Ave., Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director L. Hart Ruck
(b) Address 5305 Harford Rd.

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Huntington Williams M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1948, at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1948 to Jan. 11 1948, and that I last saw him alive on Jan. 11 1948

Immediate cause of death: Intestinal Obstruction — Duration: 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan. 10, 1948

Major findings of operation: Intestinal Obstruction — Carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mortimer Lee Hillman M. D.
Address Union Memorial Hospital Date signed 1-11-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58948

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 S. Haven
(c) Hospital or institution: 26-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. Haven St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angela Farinaccio

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: ~~xxxx~~ Nicola Farinaccio

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6 1893

8. AGE: Years 54 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

FATHER
12. Name Vincenzo Petroniero
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Stecca
15. Birthplace Italy

16 (a) Informant Nicola Farinaccio
(b) Address 124 S. Haven St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Jan. 13/48 (month) (day) (year)

(c) Cemetery or ~~Crematory~~ Oak Lawn
Location Baltimore Md.

18 (a) Funeral director Frank Selby Hoen
(b) Address 52 N. Morley St.

19 (a) JAN 12 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1948, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2, 1947 to Jan. 9, 1948, and that I last saw her alive on Jan. 9, 1948

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Cerebral Hemorrhage	6 month
Due to: Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip Leon Artigiani M. D.
Address 2942 E. Fayette St. Date signed 1/12/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658949 JL -116350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 658949

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 N. Colvin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Acuri

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Brigida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1874

8. AGE: Years 73 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Domenico Acuri

13. Birthplace Italy

MOTHER 14. Maiden Name Maria Sansone

15. Birthplace Italy

16 (a) Informant Baltimore City Hosp. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd & Balt. Md

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Hanley St

19 (a) ~~Jan 10 1948~~ (b) Huntingdon Williamsport
(Signature of registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1948 at 6.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1948 to Jan. 10 1948 and that I last saw him alive on Jan. 10 1948

Immediate cause of death	Duration
Pneumonia, Lobar	
Due to —	
Due to —	
Other Conditions Arteriosclerosis Renal Disease - Uremia (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm R Dearborough M. D.

Address Balto City Hosp. Date signed 1-11-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G58950

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 63
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Chester (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angelina ~~Angello~~ STEELE

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-24-7517

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1929

8. AGE: Years	Months	Days	If less than one day
18	2	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Antony Amarello
13. Birthplace Italy

MOTHER
14. Maiden Name Paolina Rutello
15. Birthplace Italy

16 (a) Informant Paolina Amarello (Mother)
(b) Address 205 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Balt. Md

18 (a) Funeral director Frank Della Vale
(b) Address 52 N. Morley St

19 (a) JAN 12 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1948, at 10:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
~~Due to~~ Fractured pelvis
Fractured tibiae and fibulae

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-11-48 at 9:30 P.M.
(b) Where did injury occur? Broadway & Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? not
(d) Means of injury Pedestrian struck by auto

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 1/12/48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58951
QC- G 95538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G58951
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5111 Brookwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA ANN WINGATE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 26, 1947

8. AGE: Years	Months	Days	If less than one day
	1	16	hr. min.

9. Birthplace Anne Arundel Co., Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William J Wingate
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Charlotte W. Lilly
15. Birthplace Maryland

16 (a) Informant Wm. J. Wingate
(b) Address 5111 Brookwood Rd. (Father)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Ritchie Hghwy.

18 (a) Funeral director J. A. Krause & Son
(b) Address 1216 E. Chase St.

19 (a) JAN 12 1948 (Date filed by registrar) Hunter for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1948, at 6:00 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emile Roy M.D.
Medical Examiner
Date signed 1-11-47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658952

BALTIMORE CITY HEALTH DEPARTMENT

TM. 116194

CERTIFICATE OF DEATH 138

Registered 658952

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore, City Hospitals 17.1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 St. Barnabas Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Richardson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Seperated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19th. 1899

8. AGE: Years	Months	Days	If less than one day
48	2	20	hr. min.

9. Birthplace S. C (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name George Richardson
13. Birthplace S. C

MOTHER 14. Maiden Name Charlotte Thomas
15. Birthplace S. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 1/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elbon & Wilson
(b) Address 1500 Brantly Ave

19 (a) JAN 12 1948 (b)
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION P M

20. DATE OF DEATH January 8th 19 48 at 10.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 19 47, to Jan. 8th 19 48, and that I last saw h im alive on January 8, 1948

Immediate cause of death Acute Heart failure — Duration

Due to Miliary tuberculosis — 2 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature U C Bennett M. D.
Address Baltimore City Hosp Date signed 1/11/48

X

Medical & Surg. Case
Referred to Hosp.
446946

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 180

Registered No. 5589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 87
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 E. Biddle, St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabel Daniels

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
75 74			hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Stephen Melnick
13. Birthplace N. C.

MOTHER 14. Maiden Name Hedeley ?
15. Birthplace N.C.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md
18 (a) Funeral director Elroy S. Wilson
(b) Address 1000 Stanley ave
19 (a) JAN 12 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9- 1948 at 11:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1948 to 1-9- 1948
and that I last saw h[illegible] alive on 1-9- 1948.

Immediate cause of death	Duration
Pneumonia Bilateral - Bronchopneumonia	
Due to Diabetes	
Due to [illegible]	
Other Conditions Diabetes Mellitus & Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. D.
Address (Date signed)

VS 150

Dr. Sanford

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G58954

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 827 N. Fremount Ave.
(c) Hospital or institution: 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Burton

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Greensville, S. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Edward Fuller
13. Birthplace Va.

MOTHER
14. Maiden Name Marie ?
15. Birthplace

16 (a) Informant Odell Burton
(b) Address 827 N. Fremont Ave.

17 (a) Burial (b) Date thereof 1/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenville,
Location South Carolina

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 JAN 12 1948 Chester for Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1947, to 1-9 1948 and that I last saw h[illegible] alive on 1-9 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	1 Day
Due to Hypertensive Cardio-vascular renal disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 803 N. Fremont Date signed 1-10-48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C58955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

C58955 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Cathedral Street
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Cathedral
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Mary Edmonia Stone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Francis W. Stone
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1857

8. AGE: Years	Months	Days	If less than one day
90	11	19	-- hr. -- min.

9. Birthplace Pomfret, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ------

FATHER
12. Name Robert Hunt
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Luckett
15. Birthplace Virginia

16 (a) Informant Mrs. Martha E. Roby
(b) Address 514 Cathedral Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/48 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Pomfret, Md.

18 (a) Funeral director Wm. H. Means and Son
(b) Address 805 N. Calvert Street

JAN 13 1948 (Date rec'd by registrar) (b) Carrington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11-1948 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Jan 11 1948 and that I last saw h alive on Jan 10 1948

Immediate cause of death Bronchial Pneumonia — Duration 3 Dy
Due to Contributory Arteriosclerosis — Duration Yrs
Due to Senility — Duration Yrs
Due to ——— Duration
Other Conditions ———

(Include pregnancy within 3 months of death)
Date of operation ———
Major findings of operation: ———
of autopsy: ———

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ———
(b) Date of occurrence ——— at ——— M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. E. Kepler M. D.
Address Medical Arts Bldg Signed 1-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6589-6 30E

Registered No. 6589-56

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 LINNARD ST
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 LINNARD ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS H. KAISER ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	WIDOWER

6 (b) Name of husband or wife NORA

6 (c) If alive, where? DECEASED

7. Birth date of deceased (mo., day, yr.) NOV 11 1884

8. AGE: Years	Months	Days	If less than one day
63	1	30 29	hr. min.

9. Birthplace LAUREL MD. (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER 12. Name NOT KNOWN
13. Birthplace

MOTHER 14. Maiden Name NOT KNOWN
15. Birthplace

16 (a) Informant JOHANNA EBEL
(b) Address 603 LINNARD ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-13-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location FREDERICK AVE

18 (a) Funeral director GEO. H. LEIMBACH
(b) Address 525 N. LYNDHURST ST.

19 (a) (Date and place registered) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1948 at 5:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1945 to Dec 1947 and that I last saw alive on 12-30 1947

Immediate cause of death: Cardiac failure — Duration: Sudden

Due to hypertension & Hypertensive Cardio-vascular disease — 5 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Harrell Peirce M. D.
Address 312 Med. arts Bldg Date signed 1-12-48

Washington Williams 48 1-12

X

G58957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G58957

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: nursing home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Cockeysville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Zinke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15 1876

8. AGE: Years	Months	Days	If less than one day
71	1	28	hr. min.

9. Birthplace Cockeysville, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Zinke
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Barbara Hoffman
15. Birthplace Balto. Co. Md.

16 (a) Informant Walter Tyrie
(b) Address Cockeysville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-48 (month) (day) (year)
(c) Cemetery or crematory Sherwood Ests
Location Cockeysville, Md

18 (a) Funeral director Ladd & Brooks
(b) Address Sparks, Md

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) Filing No. Millington 15

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1948 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3-20-1946 to Jan. 12-1948, and that I last saw him alive on Jan. 10-1948

Immediate cause of death Cerebral Hemorrhage

Due to adv. atherosclerosis

Due to

Other Conditions Post-cerebral paralysis due to trauma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Jacob, M.D.
M. D.

Address 1700 Eutaw Place Date signed 3-12-48

658958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

658958 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1839 W. Lanvale St.
(c) Hospital or institution: 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ina C. Christopher

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife James E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1/78

8. AGE: Years	Months	Days	If less than one day
70	0	19	hr. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name William H. Shriner
13. Birthplace Carroll Co. Md

MOTHER
14. Maiden Name Anna E. Fleagle
15. Birthplace Carroll Co. Md.

16 (a) Informant Charles M. Shriner
(b) Address 165 King George St. Annapolis

17 (a) [illegible] (b) Date thereof Dec 13 1948
(If cremation, crematory; if removal) (month) (day) (year)
(c) Cemetery or crematory Rehobbth Church
Location Northumberland Co. Va.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 JAN 13 1949 [illegible] Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1949 at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Jan 10 1949 and that I last saw h[illegible] alive on Jan 9 1949.

Immediate cause of death	Duration
Respiratory failure	
Due to Hypertensive and arteriosclerotic cardiovascular	
Due to Renal disease	
Other Conditions Hemoglobin	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Sborofsky M.D.
Address 601 N. Monroe St Date signed 1/12/49 M. D.

VS 150

X

G58959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G58959 Registered No. Over

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 N. Belnord Ave.
(c) Hospital or institution: 62
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Belnord Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD JOSEPH WARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dorothy M. Allgeier
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1890

8. AGE: Years	Months	Days	If less than one day
57	5	24	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business School #93

FATHER
12. Name Edward J. Ward
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Duffey
15 Birthplace Ireland

16 (a) Informant Dorothy, M. Ward
(b) Address 211 N. Belnore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4400 Belair Road

18 (a) Funeral director Tilly & Zeiler Inc.
(b) Address 403 South Wolfe St

19 JAN 13 1948 (Date received by Registrar) Hattie M. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1948 at 420 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Jan 10 1948 and that I last saw him alive on 19

Immediate cause of death	Duration
(a) Uremic Coma	1/6/48
Due to (b) Ch Interst. Nephritis	1/10/47
Due to (c) Cirrhosis of Liver	1/10/47
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Roarer M.D.
Address 801 N. Kenwood Ave. Date signed 1/12/48

VS 150

G58960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

G55960 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cambridge St
(c) Hospital or institution: 1-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cambridge St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Perc

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1898

8. AGE: Years	Months	Days	If less than one day
50	8	11	hr. min.

9. Birthplace Poland (town, county, and state)
10. Usual Occupation Chifer
11. Industry or business

FATHER 12. Name John Perc
13. Birthplace Poland

MOTHER 14. Maiden Name Catherine Kulasz
15. Birthplace Poland

16 (a) Informant Gertrude Perc
(b) Address 2101 Cambridge St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15 48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Orazewski
(b) Address 1930 Eastern Ave

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 19 48 at 9:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 47 to Jan 12 19 48, and that I last saw h.i.m. alive on 12 Jan 19 48

Immediate cause of death: Carcinoma, stomach & metastasis To liver — Duration: 9 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Nov. 1947
Major findings of operation: Carcinoma, stomach & metastasis To liver
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 2858 Harford Rd Date signed M. 12 D. 40

V S 150

X

G58961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G58961 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 S Elwood Ave.
(c) Hospital or institution: 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street 500 S. Elwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanislaw Stanley Gorski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Wanda Gorski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 /1895

8. AGE: Years	Months	Days	If less than one day
52	8	2	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Alexander Gorski
13. Birthplace Poland

MOTHER 14. Maiden Name Victoria Lubinski
15. Birthplace Poland

16 (a) Informant Wanda Gorski
(b) Address 500 S Elwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) Huntington Nitt[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1947 to Jan 10 1948, and that I last saw h alive on Jan 10 1948

Immediate cause of death — Duration
Cerebral Apoplexy — 3 dy
Due to Hypertension — 2 yr
Due to Arterio-Sclerosis — 10 yr
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A. F. Rice M. D.
Address 24 S. Broadway Date signed Jan 21 1948

V S 150

X

G58962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G58962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 W. Saratoga St.
(c) Hospital or institution: 181
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) over 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 W. Saratoga St. Apt. "X
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bettie Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 64 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Charlotte Co., Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Thomas Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Va.

16 (a) Informant Mrs. Annie Oliver
(b) Address 817 Saratoga St. Apt. 7

17 (a) Burial (b) Date thereof 1-14-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Aspen, Virginia

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) [illegible] Huntington Williams, MD
(Date rec'd by registrar) JAN 13 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10, 1948 19..., at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-1947 to 1-10-1948, and that I last saw h- alive on 1-9-1948

Immediate cause of death: Carcinoma of lung — Duration: unknown
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dwight D. Saunders
Address 1128 N. Streiger Date signed 1-12-48

G58963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 106 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 Hollins St.
(c) Hospital or institution: 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LeROY JOSEPH HENNESSEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Katherine M. Hennessey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1897

8. AGE: Years	Months	Days	If less than one day
51	0	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Transportation Dept.
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name John T. Hennessey
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Katherine Heaphy
15 Birthplace Balto., Md.

16 (a) Informant Mrs. Katherine M. Hennessey
(b) Address 829 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 12 1948 Received by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1948 to Jan 9 1948 and that I last saw alive on Jan 6 1948.

Immediate cause of death: Acute Cardiac dilatation — Duration 1 hr.
Due to: Chronic bronchitis — Duration 2 yrs.
Due to:
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. N. Fuston M. D.
Address H. N. Fuston Date signed 1-11-48.

G58964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/108

G58964 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD AVE
(c) Hospital or institution: CONVALESCENE HOME 167
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 YEARS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 4709 HARFORD GROVE St. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MARY MILLER.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOW
6 (b) Name of husband or wife: HENRY S. MILLER
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): AUG. 7, 1868
8. AGE: Years 79 | Months 5 | Days 3 | If less than one day: hr. min.
9. Birthplace: BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation: HOUSEWIFE
11. Industry or business: HOME

FATHER
12. Name: JOHN G. UNTZ
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: MARGARET (UNKNOWN)
15. Birthplace: GERMANY

16 (a) Informant: MR. EDWARD C. MILLER
(b) Address: 3216 WESTWOOD AVE
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)
(c) Cemetery or crematory: LORRAINE CEM.
Location: WOODLAWN, MD.
18 (a) Funeral director: WM. J. TICKNER & SONS INC
(b) Address: NORTH & PA., BALTO. MD.
19 JAN 13 1948 (Date rec'd by Registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 10 1948, at 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 3 1948 to JAN 10 1948 and that I last saw her alive on JAN 10 1948

Immediate cause of death		Duration
LOBAR PNEUMONIA	JAN 3	1948
CHRONIC MITRAL REGURGATION		1946
Due to: CHRONIC MYOCARDITIS		1946
Due to: ARTERIOR SCLEROSIS		1946
Other Conditions: NONE		

(Include pregnancy within 3 months of death)
Date of operation: NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Chas. F. Adams M. D.
Address: 3013 ST PAUL STREET Date signed: JANUARY 10 1948

VS 150

G58965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

189a

Registered No. G58965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital 9-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 53 days

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2623 GREENMOUNT AVE.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Raymond Frank Von Dreele

3 (b) If veteran, name war --

3 (c) Social Security Account No. 212-12-2092

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 27, 1914

8. AGE: Years 33 | Months 1 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Messman

11. Industry or business Seafarer

FATHER

12. Name Raymond Frank Von Dreele Sr.

13. Birthplace Balto, Md.

MOTHER

14. Maiden Name Gertrude GORDON

15 Birthplace Balto, Md.

16 (a) Informant Records

(b) Address US Marine Hospital

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/15/48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TURNER & SONS INC

(b) Address NORTH & PA. AVE.

19 JAN 13 1948 Hunter for Williams M.D.

(Date rec'd by registrar) Registrar

VS 15C

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1948, at 4:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1947 to Jan. 12 1948, and that I last saw him alive on Jan. 12 1948

Immediate cause of death Abscess right temporal lobe.

Due to Chronic otitis media and osteomyelitis of petrous portion of temporal bone, right side

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration
TWO MONTHS

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John L. Wilson

John L. Wilson, Sr. Surgeon M.D.

Address Clinical Director Date signed 1/12/48

G58966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G58966 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution: Garrison Nursing Home 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mo.s
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5620 Mattfeldt Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNIE E. NIPPARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jun 25, 1873

8. AGE: Years	Months	Days	If less than one day
74	6	16	hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Francis Alexander Hamilton
13. Birthplace New York City

MOTHER
14. Maiden Name Emma James
15 Birthplace Annapolis, Md.

16 (a) Informant Mr. John C. Nippard
(b) Address 1906 Chelsea Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves., Balto, Md.

19 (c) JAN 13 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11th 1948, at 7:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1948 to Jan 11 1948 and that I last saw her alive on Jan 11 1948.

Immediate cause of death Coronary Thrombosis — Duration 5 days
Due to
Due to
Other Conditions Coronary Sclerosis — years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Mendelis M. D.
Address 651 N Bentalou Date signed 1-12-48

X

58967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 81a

Registered No. 58967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Ba l timore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2733 Cylbu[illegible] Ave.
(If rural give location)
(e) Citizen of foreign country? ** (Yes or No)
If yes, name country

3 (a) FULL NAME Hans C. Hansen

3 (b) If veteran, name war: **

3 (c) Social Security Account No. Yes

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Augusta C. Norgard

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1882

8. AGE: Years: 65 | Months: 0 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Denmark (Town, county, and state)

10. Usual Occupation: Black & Decker

11. Industry or business: **--

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unkno wn
15. Birthplace: Unknown

16 (a) Informant: Mr. Eugene m. Hansen
(b) Address: 2733 Cylburn Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/14/48 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Ba ltimore, Md.

18 (a) Funeral director: WM. J. TIKKNER & SONS IN
(b) Address: North & Pa. Aves; Balto., Md.

19 (a) [illegible] 9 1948 (b) [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1948 at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1948 to 1-11 1948 and that I last saw him alive on 1/11 1948

Immediate cause of death: Cardiac arrest.

Due to: Pneumonia

Due to: pneumococcus

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: [illegible]
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Hall M. D.
Address University Date signed 1/14/48

VS 150

G58968

G58968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Granbury St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel E. Goodwin

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Hattie Goodwin
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 12, 1865

8. AGE: Years	Months	Days	If less than one day
82	9	28	..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Not given: RETIRED
11. Industry or business

FATHER
12. Name Daniel E. Goodwin
13. Birthplace Carroll County Maryland

MOTHER
14. Maiden Name Margaret [illegible]
15 Birthplace Carroll County Md.

16 (a) Informant Hattie Goodwin
(b) Address 2921 Granbury St (16)

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location Balto, MD.

18 (a) Funeral director W.M. J. TICKNER & SONS INC
(b) Address W. 28th & Pa. Ave. Balto, MD.

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1948 to 1/10 1948 and that I last saw him alive on 1/10 1948

Immediate cause of death	Duration
Heart failure	
Hypostasis	
Due to Pneumonia	1 wk.
Due to Arteriosclerotic Cardio-vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry V. Chase M. D.
Address Mercy Hospital Date signed 1/10/48

G58969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G58969 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. 2804 Lanvale St.
(c) Hospital or institution: -- 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Ba ltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 W. Lanevale St
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME MARY REBECCA SIMMONS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: --

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Taylor Z.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 14, 1865

8. AGE: Years 82 | Months 8 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Levi Taylor
13. Birthplace Maryland

MOTHER
14. Maiden Name ---- Ebaugh
15. Birthplace Maryland

16 (a) Informant Mr. Harry W. Shenton
(b) Address 1111 Munsey Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves; Balto., Md.

19 JAN 12 1948 (Date rec'd by Registrar) Hamilton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 19 48, at 8: 40P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1947 to Jan 11 1948, and that I last saw h-V alive on Jan 11 19 48.

	Duration
Immediate cause of death: Cardiac Insufficiency	
Due to: Gen-Arteriosclerosis	2
Due to:	
Other Conditions: Bronchopneumonia	3 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Green M. D.
Address 1761 E Nora Date signed 1/12/48

95c

G58970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G58970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn (b) County
(c) City or town Bridgeport (If outside city or town limits, write RURAL and give town)
(d) Street No. RFD #1 Box 300 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Hartley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 13, 1942

8. AGE: Years	Months	Days	If less than one day
5	3	29	hr. [redacted] min.

9. Birthplace Conn (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name Lowell Hartley
13. Birthplace

MOTHER 14. Maiden Name Rachel Virta
15. Birthplace Finland

16 (a) Informant JOHNS HOPKINS HOSPITAL Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/13/48 (month) (day) (year)
(c) Cemetery or crematory
Location Bridgeport, Conn

18 (a) Funeral director Wm. J. Freeman Sons
(b) Address 1701 Aisquith

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION 10

20. DATE OF DEATH Jan 12 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1948 to Jan 12 1948 and that I last saw him alive on Jan 12 1948

Immediate cause of death Cardiac Failure — Duration 45 min

Due to Congenital Heart Disease — 5 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 12 January 48
Major findings of operation: Dilated heart
of autopsy: Cong. Malformation heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R Cantley M.D.
Address Johns Hopkins Hosp. Date signed 17 Jan 48

VS 190

G58971 Reg. 116494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 X

Registered No. G58971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ Hour
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Essex B lto. CO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 247 RT. 16 Miles RD Balto 21
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grau Adam

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11- 1865

8. AGE: Years	Months	Days	If less than one day
82	11	-	hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14th (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location

18 (a) Funeral director Wellrich Funeral Home
(b) Address 2108 Orleans St

19 (a) JAN 13 1948 (Date rec'd by registrar) Clarence Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 - 1948, at 145P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1948 to 1-11-48, and that I last saw him alive on Jan. 11- 1948

Immediate cause of death Diffuse generalized peritonitis — Duration 72 hrs.

Due to perforation of bladder, (spontaneous?)

Due to

Other Conditions Abscess in fundus of bladder (S.H.D.)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maureen M. Lacy M.D.
Address Baltimore City Hosp. Date signed 1-11-48

VS 150

135a

G58972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G58972 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3601 Cottage Ave
(c) Hospital or institution: 15-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3601 Cottage Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pasach Leuman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Irvens
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Rose Leuman
(b) Address 3601 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-48 (month) (day) (year)

(c) Cemetery or crematory
Location Mt Lebanon-Loudale

18 (a) Funeral director Jack Levin Inc
(b) Address 2406 Eutaw Place

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12-1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1945 to Jan. 13 1948, and that I last saw h[illegible] alive on Jan. 12 1948.

Immediate cause of death	Duration
Coronary Thrombosis	15 minutes
Due to Hypertension, Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Blum, M.D.
Address 2310 Eutaw Pl. Date signed 1/13/48 M. D.

G58973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G58973 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 Ridgely St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISRAEL MICHAELSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Shoemaker

11. Industry or business

FATHER 12. Name Kessen
13. Birthplace Russia

MOTHER 14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Annie Michaelson
(b) Address 802 Ridgely St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-48 (month) (day) (year)
(c) Cemetery or crematory
Location Nethrew-Nevring Lee

18 (a) Funeral director Jack Rewbe Jr
(b) Address 2149 Eutaw Place

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) Huntington, West Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 12 1948, at 6:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC. 23 1947 to JAN. 12 1948, and that I last saw HIM alive on JAN. 12 1948

Immediate cause of death	Duration
PERIURETERAL ABSCESS, RIGHT.	1-2 WEEKS
Due to CARCINOMA OF THE URINARY BLADDER	1 YR.
Due to	
Other Conditions ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Date of operation JAN. 1947

Major findings of operation: CA OF BLADDER.

of autopsy: ABSCESS, PERIURETERAL, RT.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Lerman M. D.
Address Sinai Hosp. Date signed 1-12-48

658974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

658974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 Dukeland St
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Dukeland St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Yatt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 52 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Morton
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Mrs. Edith Yatt
(b) Address 1925 Dukeland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) Huntington Avenue

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12-1948, at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Jan 12 1948, and that I last saw h[illegible] alive on Jan 12 1948.

Immediate cause of death: Coronary thrombosis — Duration: 3 days
Due to: Arteriosclerosis — Duration: several years
Due to:
Other Conditions: Pernicious Anemia
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S.C. Smith M.D.
Address 122 35 Worth Date signed 1/13/48

V S 150

X

G58975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 a

Registered No. G58975

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution Providence Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2527 W. Cullen St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Catherine Woolford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Levin W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27 1868

8. AGE: Years 79 | Months 2 | Days 14 | If less than one day: hr. min.

9. Birthplace Dorchester Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Cannon
13. Birthplace Dorchester Co. Md.

MOTHER
14. Maiden Name Mahala Cannon
15. Birthplace Dorchester Co. Md.

16 (a) Informant Mrs. Julia Leath
(b) Address 2527 W. Cullen St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Capt. A. Hollard
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 13 1944 (Date rec'd by registrar) (b) Huntingtor Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1944, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1944 to Jan 10 1944 and that I last saw h.. alive on Jan 10 1944.

Immediate cause of death: Cardio-Vascular-Renal disease — Duration: 2 months

Due to

Due to

Other Conditions Uremia — 6 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
(f) Signature George McDonald M. D.
Address 844 N. Carey Date signed 1/12/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658976

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 658976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special care is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3426 Lyndale ave
(c) Hospital or institution: 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No 3426 Lyndale ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Lehr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Mary M. Lehr
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 11 - 1859
8. AGE: Years 88 | Months 4 | Days - | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired Plumber
11. Industry or business

FATHER
12. Name Mr Peter Lehr.
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Germany

16 (a) Informant Norman A Lehr
(b) Address 570 Oakland Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 194 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore Md.
18 (a) Funeral director Jeannie Cook & Son
(b) Address 1605 W. North Ave
19 JAN 13 1948 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 - 1948, at 1-45 PM
21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Jan 11 1948 and that I last saw h alive on 19
Immediate cause of death: Acute Cardiac Failure
Due to: Arteriosclerotic Cardio-Vascular Disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. B. Stevens M.D.
Address 3405 Eldmont Ave Date signed 1/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G58977 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 639 S. Linwood Ave.
(c) Hospital or institution: Home 1-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 639 S. Linwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob Danieecki

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-0712

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Helen Danieecki
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 29 1889

8. AGE: Years	Months	Days	If less than one day
58 59	9	13	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Jacob Danieecki
13. Birthplace Poland

MOTHER
14. Maiden Name Franciszka Smolenski
15. Birthplace Poland

16 (a) Informant Helen Danieecki
(b) Address 639 S. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location Germans Mill Rd

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1948 at 10 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 11 1948 and that I last saw h. alive on Jan 10 1948.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Coronary Artery	
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ira Thompson M.D.
Address 3503 Fleet Date signed 1-13-48

V S 150

DR KOLDEWEY 27 N. CAREY ST ✓

658978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

658978 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey Street
(c) Hospital or institution: Good Samartian Nursing Home 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 647 W. Laxington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET L. RYAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1875

8. AGE: Years	Months	Days	If less than one day
72	6	7	hr. min.

9. Birthplace New York, N. Y.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15 Birthplace "

16 (a) Informant Mrs. Anna Thome
(b) Address 111-32 Seventy-Fifth Road

17 (a) Burial (b) Date thereof Jan. 14, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 JAN 13 1948 Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

VS 189

MEDICAL CERTIFICATION

P

20. DATE OF DEATH January 11 1948, at 7:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 29 1947 to Jan 11 1948 and that I last saw her alive on Jan 11 1948

Immediate cause of death	Duration
Cerebral Renal	
Due to Hypertension	
Due to Uremia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alice Koldewey M. D.
Address 27 N Carey St Date signed 1/12/48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

658979 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 18-7
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis H Reilley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of ~~husband or wife~~: Alice Reilley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18 1872

8. AGE: Years 75 | Months 4 | Days 23 | If less than one day: hr. min.

9. Birthplace Boston
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Unknown

13. Birthplace "

14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs Wicks

(b) Address 833 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Wilhelm Corpse

(b) Address 1317 Lombard St

19 JAN 13 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Jan 1948, at 12-30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Dec 1947, to 11 Jan 1948, and that I last saw him alive on 11 Jan 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertensive C. V. Disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.

Address Franklin Sq Hosp Date signed 11 Jan 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~858980~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G58980

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 N. Calhoun St
(c) Hospital or institution: Franklin Sq. Hosp. 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days) B
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 3 Hayward Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Wolf

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 - 1891

8. AGE: Years	Months	Days	If less than one day
56	6	29	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Retired fireman
11. Industry or business

FATHER
12. Name Sylvester Wolf
13. Birthplace Pa.

MOTHER
14. Maiden Name Carrie Farah
15. Birthplace Eng

16 (a) Informant Annat Wolf (wife)
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-48 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel
Location Pikesville Md.

18 (a) Funeral director Lorenz Bros
(b) Address 5005 Park Heights Ave

19 JAN 13 1948 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Jan 1948, at 8 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Jan 1948, to 10 Jan 1948, and that I last saw h[illegible] alive on 10 Jan 1948.

Immediate cause of death Infarction of myocardium — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.

Address Franklin Sq Hosp Date signed 10 Jan 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

658981 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Granby St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yustinus Lewrinaitis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1942

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location 6' Donnell St

18 (a) Funeral director L. Heemann & Son
(b) Address 6067 Harford Rd

19 JAN 13 1948 (Date received by Registrar) Washington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1948, at 7:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Beyer M.D.
Medical Examiner.
Date signed 1-9-48

G58982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G58982 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1048 Brantly Ave.
(c) Hospital or institution: 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1048 Brantly Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jessie Conner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Pickins, S. C. (Town, county, and state)

10. Usual Occupation Salad Girl

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Emma Holloway

(b) Address 2452 E. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15, 1948 (month) (day) (year)

(c) Cemetery or crematory Loretto Cem.

Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantly Ave.

JAN 13 1948 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

1/12/48

20. DATE OF DEATH Jan 12 1948, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947, to Jan 12 1948 and that I last saw her alive on Jan 11 1948

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Due to Hypertensive CVHD	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard Applegarth, M.D.

Address 254 Reservoir Hill Rd Date signed 1/12/48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63c ✓

Registered No. G58983

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital 16-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 N Fulton Av (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wright, Catherine E

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 89

8. AGE: Years	Months	Days	If less than one day
56	1	6	hr. min.

1891

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Eugene Hallgran
13. Birthplace Ireland

MOTHER
14. Maiden Name Not Known
15. Birthplace Illinois

16 (a) Informant Sealon C Wright
(b) Address 710 N Fulton st

17 (a) Burial (b) Date thereof 1-15-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore Md

18 (a) Funeral director Joyce & Farley
(b) Address Fulton & Fayette

19 (a) JAN 13 1948 (b) Transcribed for Williams, ABR
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12, 1948, at 10 3/5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1948 to Jan 12 1948, and that I last saw her alive on Jan 12 1948

Immediate cause of death	Duration
Cardiac decompensation	
Due to Arterial thrombosis	
Due to	
Other Conditions Myxedema	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Univ. Hosp. Date signed 1/12/48

VS 130

95c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

G58984 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern Ave
(c) Hospital or institution: City Hospital 183
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 Hollins st
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J HEYING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Mary

6 (c) If alive, Average years

7. Birth date of deceased (mo., day, yr.) Feb 22 1890

8. AGE: Years 57 | Months 2 10 | Days 20 19 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Theodore Heysing

13. Birthplace Germany

MOTHER 14. Maiden Name Caroline Hinke

15. Birthplace Germany

16 (a) Informant Augusta [illegible]

(b) Address 124 N Broadway

17 (a) Burial (b) Date thereof 1-14-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Balto Co County

18 (a) Funeral director Geo A Hardy

(b) Address Fulton Ave Lafayette

19 (a) JAN 13 1948 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1948, at 5 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to Fatty degeneration of liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Geo A. Magill M.D.
Medical Examiner.

Date signed 1/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G58985

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-2
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Blake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Essex Co. Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Jacobs Blake

13. Birthplace Va.

MOTHER 14. Maiden Name Susan Ritchie

15. Birthplace Va.

16 (a) Informant Kate Blake

(b) Address 1035 Fair Mount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location West Fort Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home

(b) Address 927 N. Monroe St.

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1948, at 1:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial hypertrophy, dilatation and degeneration.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 1-10-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. 658986

Over

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 16-3
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 N. Bunker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/9/1920

8. AGE: Years	Months	Days	If less than one day
40 28		1	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer Shredder

11. Industry or business

FATHER 12. Name Frank L. Boone
13. Birthplace S. C.

MOTHER 14. Maiden Name Amyda Fisher
15. Birthplace S. C.

16 (a) Informant Rosa Vylt Boone
(b) Address 909 Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Part Balto, Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 923 N. Mount St.

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) Awaiting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1948, at 6:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Puncture - wounds of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/10/48 at 5:00 P.M.
(b) Where did injury occur? 1723 W. Lafayette Ave Balto Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Sharp instrument

23. Signature George H. Merrill M.D. Medical Examiner.
Date signed 1/12/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 658987

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2619 Boone St
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2619 Boone St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rena Irene Hopp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1878

8. AGE: Years 69 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Ossie Wheeler
13. Birthplace Md

MOTHER
14. Maiden Name Bettie Mills
15. Birthplace Md

16 (a) Informant Mrs Mary Thomas
(b) Address 2619 Boone St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co.

18 (a) Funeral director Gaynor Sanders
(b) Address 1412 E Preston St

19 JAN 13 1948 (Date rec'd by registrar) (b) Lavington for Williams M.D. Registrar

V-S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1948, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to Jan 12 1948 and that I last saw h[illegible] alive on Jan 12 1948.

Immediate cause of death: Cardio Renal Disease — Duration: 7 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul D. Johnson M.D.

Address 2329 Jeep St Date signed Jan 13 1948

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

658988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 658988

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-15
(b) Street address.....
(c) Hospital or institution: 2101 Cold Spring Lane
Elkins Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

3 (a) FULL NAME JOSEPH F. GRAHAM

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Catherine Grace Graham
6 (c) If alive, give age 68 years
7. Birth date of deceased (mo., day, yr.) Dec. 29-1876
8. AGE: Years 71 | Months - | Days 12 | If less than one day .....hr. .....min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Druggist
11. Industry or business

FATHER
12. Name John T. Graham
13. Birthplace England

MOTHER
14. Maiden Name Rose McGahan
15. Birthplace Maryland

16 (a) Informant Mr. William L. Grace
(b) Address 704 Beaumont avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location.....

18 (a) Funeral director Chas. J. Evans Son Inc
(b) Address 118 W. Mt. Royal Ave

19 JAN 13 1948 (Date rec'd by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 19 48 at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1948 to 1-11 1948, and that I last saw him alive on 1-11 1948.

Immediate cause of death	Duration
CORONARY OCCLUSION	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature Norman R Kleiman M. D.
Address 3803 Edmondson Ave Date signed 1/14/48

X

Dr. Grott

G58989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G58989

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2912 Glendale Avenue
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Glendale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hannah Slaybaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1871

8. AGE: Years	Months	Days	If less than one day
76	11	26	hr. min.

9. Birthplace Missouri
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name ? Miller
13. Birthplace ?

MOTHER
14. Maiden Name ? Foster
15. Birthplace ?

16 (a) Informant Mr. Arthur Waswo
(b) Address 2912 Glendale Avenue, 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) JAN 13 1948 (Registered by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12th, 1948, at 6 30/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1948 to 1/12 1948, and that I last saw h. alive on 1/11 1948

Immediate cause of death: Cerebral Hemorrhage — Duration: 12 hrs.

Due to: Hypertensive cardio- — ?

Due to: Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Grott M. D.

Address 8100 Harford Rd Date signed 1/12/48

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58990 BC + 4810 58 — Registered No. G58990

GM. 116475

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Hinton (Elizabeth)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9 -1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Henry Hinton
13. Birthplace N.C.

MOTHER — 14. Maiden Name Elizabeth Horton
15. Birthplace N.C.

16 (a) Informant Records B lto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1-12-48 (month) (day) 9:00 AM (year)
(c) Cemetery or crematory B.C.H.
Location 4940 Eastern AVE.

18 (a) Funeral director
(b) Address

19 JAN 13 1948 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 - 1948, 12.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 -1948, to Jan. 11 1948, and that I last saw h. alive on Jan. 11 1948

Immediate cause of death	Duration
Bronchopneumonia	1 day
Due to Prematurity	1 day
Other Conditions Aspiration?	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt City Hosp Date signed 12 Jan 48

058991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 058991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 S. Curley St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S. Curley St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME Laurence F. Fiecto

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bridet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-1879

8. AGE: Years	Months	Days	If less than one day
68	6	6	hr. min.

9. Birthplace Michigan (Town, county, and state)

10. Usual Occupation Lithographer

11. Industry or business

FATHER
12. Name Felix Fiecto
13. Birthplace ?

MOTHER
14. Maiden Name Matilda ?
15 Birthplace ?

16 (a) Informant Bridget Fiecto wife
(b) Address 620 S. Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director Lilly & Zigler
(b) Address 403 S. Wolfe St.

19 JAN 13 1948 (Date rec'd by registrar) (b) Funeral director for Williams, M.D. Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 — 1948, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1947 to Jan. 10 1948 and that I last saw h(er) alive on Jan. 10 1947

Immediate cause of death Chronic Myocarditis
Arteriosclerosis

Due to Chronic Bronchitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Tamburo M.D.

Address 1641 N. Elwood Ave Date signed 1/12/48

0588992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. 0588992

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 Menlo Drive-15
(c) Hospital or institution: ----- 27-20
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) Life --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Ba ltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Menlo Drive
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET ANN BRADY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Thomas J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1902

8. AGE: Years	Months	Days	If less than one day
45	3	27	..... hr. ..... min.

9. Birthplace Ba ltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business ---

FATHER
12. Name Joshua O. Griffith
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Agnes Norton
15 Birthplace Ba ltimore, Md.

16 (a) Informant Thomas J. Brady
(b) Address 3308 Menlo Drive

17 (a) Burial (b) Date thereof 1/15/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ New Cathedral
Location Ba ltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto, Md.

19 (a) JAN 13 1948 (b) Thurlington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12, 1948 19 5:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1947 to Jan 12 1948 and that I last saw h e r alive on Jan 12 1948

Immediate cause of death	Duration
Acute Cardiac Metabolism	1 day
Due to	
Due to	
Other Conditions Carcinoma of right Kidney (Include pregnancy within 3 months of death)	

Date of operation Sept 26 1947
Major findings of operation: Carcinoma of right
of autopsy: Kidney

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John G. Harman M. D.
Address 11 E. Chase St Date signed 1/13/48

95c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 658993

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address
(c) Hospital or institution: Mercy Hospital 123
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write SUBD. and give town)
(d) Street No. 2823 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis B. Beck

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No.: Yes

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Elizebeth B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 14, 1897

8. AGE: Years: 50 | Months: 6 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Brunswick, Md. (Town, county, and state)
10. Usual Occupation: Chief of Bureau of Contracts
11. Industry or business: B&O RR

FATHER
12. Name: Berl B. Beck
13. Birthplace: Martinsburg, W. Va.

MOTHER
14. Maiden Name: Ann Custer
15. Birthplace: Martinsburg, W.Va.

16 (a) Informant: Mrs. G.S. Sabine
(b) Address: 2823 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/48 (month) (day) (year)
(c) Cemetery or crematory: Rosehill
Location: Martinsburg W.Va.

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: North & Pa. Aves., Balto, Md.

19 (a) JAN 13 1948 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 1948, at 10:20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Coronary Hemorrhage

Due to: Hypertensive C.V. disease

Other Conditions: Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.

23. Signature G.S. Sabine M.D. Medical Examiner.
Date signed 1/13/48

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658994 Potocki

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 658994

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore City Jail
(c) Hospital or institution: 2-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THEODORE POTOCKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/22/11

8. AGE: Years	Months	Days	If less than one day
35	11	20	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business U.S.N.

FATHER 12. Name

FATHER 13. Birthplace Poland

MOTHER 14. Maiden Name Debrowski

MOTHER 15. Birthplace Poland

16 (a) Informant Mrs. Theresa Penkowska

(b) Address 92 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15 48 (month) (day) (year)

(c) Cemetery or crematory Mt. Stanislaus

Location Dundalk Ave

18 (a) Funeral director Marie L. Fiallowski

(b) Address 1033 S. Kenwood Ave

19 (a) JAN 13 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11, 1948, at 1 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Diabetes, mellitus

a

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Carl H. Boyer M.D. Medical Examiner.

Date signed 1-12-48

VS 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 658995

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution: 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Laurence McNeal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John McNeal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 May 1896

8. AGE: Years: 51 | Months: 9 | Days | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Emanuel Lawrence

13. Birthplace Va

MOTHER 14. Maiden Name Melvina Butler

15. Birthplace Va

16 (a) Informant John McNeal

(b) Address 1106 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14, 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Cem.

Location ~~Shirley Park~~

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 S. Schroeder St.

19 (a) JAN 13 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1948 at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1947 to 1/10 1948 and that I last saw her alive on 1/10 1948

Immediate cause of death

Duration

Due to Decubitus Ulcers & Intestinal Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. N. Hatcher M. D.

Address 1 Y r S Rem Ave Date signed 1/13/48

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G58996 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 N. Parrish St
(c) Hospital or institution: 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 N. Parrish St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Harmon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Peter Harmon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1868

8. AGE: Years 79 | Months 6 | Days | If less than one day: hr. min.

9. Birthplace Accomac Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Bill Harley
13. Birthplace Essex Co. Va

MOTHER
14. Maiden Name Melissa Snead
15. Birthplace Accomac Co. Va

16 (a) Informant Lena Sturges
(b) Address Keller Va.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Jan. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Keller Virginia

18 (a) Funeral director Mrs Katie Rebellion
(b) Address 322 N. Schroeder St

19 (a) Jan 12 1948 (Date rec'd by local registrar) (b) Kerrington for Wm. Spencer, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1948, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1947, to Jan 10 1948, and that I last saw h-- alive on Jan 6 1948.

Immediate cause of death	Duration
Due to Cerebral Hemorrhage	12 Days
Due to Chr. Myocarditis	1946
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown M. D.
Address 1623 N. North Ave. Date signed 1/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G58997

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 S. Green St
(c) Hospital or institution: 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 S. Green St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Addie Sloan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Sloan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24, 1880

8. AGE: Years 67 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Rocky Point N.C (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name George Washington

13. Birthplace Rocky Point N.C.

MOTHER 14. Maiden Name Phillis Brown

15. Birthplace Rocky Point N.C.

16 (a) Informant Lillian Washington

(b) Address 803 S. Green St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Ambrose

Location

18 (a) Funeral director Mrs Katie B. Williams

(b) Address 322 N. Schroeder St.

19 (a) JAN 13 1948 (Date received by Registrar) (b) Funeral for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11, 1948, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Jan. 11, 1948, and that I last saw h[illegible] alive on Jan. 10 1948.

Immediate cause of death: Cerebral Hemorrhage

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Sidney D. Levy

Address 1 3 V V Fountain Place Date signed 1/13/48

VS 150

C58998 JL - 115247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C58998

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 26-12
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ?
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Thomas

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
65 ?			hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-48 (month) (day) (year)
(c) Cemetery or crematory Sherwood
Location Sherwood, Md.

18 (a) Funeral director J. Cyde Moore
(b) Address [illegible]

19 (a) [illegible] 1-8-1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1948, at 11.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1947 to Jan. 12 1948, and that I last saw him alive on Jan. 12 1948.

	Duration
Immediate cause of death: (a) Bronchopneumonia	[illegible]
Due to: Cerebral Hemorrhage	1½ mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr
Address Balt. City Hosp. Date signed 1/12/48 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G58999 ✓ G58999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 644 Gorsuch Ave
(c) Hospital or institution: at home 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 57yrs.

2. USUAL RESIDENCE OF DECEASED.
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 Gorsuch
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary Hanson Stoen

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry M. Stoen
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug-9-1870

8. AGE: Years 77 | Months 5 | Days 3 | If less than one day: ____ hr. ____ min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Benj P. Hanson
13. Birthplace Delaware

MOTHER
14. Maiden Name Clara Biddle
15 Birthplace Maryland

16 (a) Informant Mrs Hanson Stoen (son)
(b) Address 1640 Chilton St. 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Stewart Mayer Co.
(b) Address 108 W Saratoga

19 (a) JAN 13 1948 (Date rec'd by registrar) Hamilton for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1948 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1947 to Jan 12 1948 and that I last saw her alive on Jan 11 1948

Immediate cause of death	Duration
Coronary Occlusion	1 hour
Due to Arteriosclerosis	?
Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis W. Sluss M. D.
Address 3406 St Paul St Date signed 1/13/48

VS 150

X

G59000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6114 Alta Avenue
(c) Hospital or institution: 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6114 Alta Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hattie E. Niblett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John E. Niblett
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Jan 9, 1879

8. AGE: Years	Months	Days	If less than one day
69	—	4	hr. min.

9. Birthplace Worcester County Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name William Timmons
13. Birthplace Maryland

MOTHER
14. Maiden Name Amelia Aydelotte
15. Birthplace Maryland

16 (a) Informant Mrs. John E. Niblett
(b) Address 6114 Alta Ave - 6

17 (a) Burial (b) Date thereof 1-16-48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Parsons Cemetery
Location Salisbury, Md.

18 (a) Funeral director Holloway & Co.
(b) Address Salisbury, Md.

19 JAN 14 1948 (b) Huntington Williams
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1948 at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Jan 13 1948, and that I last saw h[illegible] alive on Jan 13 1948.

Duration

Immediate cause of death: Acute Cardiac Failure
Due to
Due to Arteriosclerotic Cardio-Renal Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Stevens M.D.
Address 3400 Edmondson Date signed 1/13/48

9001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. 659001

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Calvert & Wilkins Ave.
(c) Hospital or institution: Sinai Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 10.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Wash D.C. (b) County
(c) City or town Washington D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1349 Mass Street N.W.
(If rural give location)
(e) Citizen of foreign country? N.D. (Yes or No)
If yes, name country

3 (a) FULL NAME Philip H. Sheridan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race ✓ | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 70+ | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (State, county, and city)

10. Usual Occupation Catholic Priest

11. Industry or business

FATHER
12. Name Thomas J. Sheridan
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Glennon
15. Birthplace Ireland

16 (a) Informant

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-14-48 (month) (day) (year)

(c) Cemetery or crematory

Location Washington D.C.

18 (a) Funeral director Wm. J. Tschan & Sons

(b) Address 11 E. Lexington Ave

19 JAN 14 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13 1948, at 11:23 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1947 to 1/13 1948 and that I last saw h[illegible] alive on 1/11 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Metastatic	
Due to Cardiac failure	
Due to Arterio Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Mertz M.D.

Address 1 E Lexington Date signed 1/13/48

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G.G59002

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital | 0-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Forrest Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: LIDA V. TIPTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1863

8. AGE: Years	Months	Days	If less than one day
85 86			hr. min.

9. Birthplace: Monkton, Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Ira A. Tipton
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden Name: Annie E. Parsons
15. Birthplace: Maryland

16 (a) Informant: Dorothy L. Ordwein
(b) Address: 516 N. Charles Streed

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 JAN 14 1948 (Date rec'd by registrar) (by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12, 1948, at 6.20 P.M.

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 1-13-48

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

658003

BALTIMORE CITY HEALTH DEPARTMENT ✓ 658003 Over

CERTIFICATE OF DEATH 163 H

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME William Fred (KOHLPACK) Kolpack ✓

3 (b) If veteran, name war: W. W. #2
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Treva Kolpack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 12th 1903

8. AGE: Years	Months	Days	If less than one day
44	4	0	hr. min.

9. Birthplace: Howard Co. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: Ferdinand Kolpack
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Renz
15. Birthplace: Germany

16 (a) Informant: Treva Kolpack
(b) Address: 807 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removed) (b) Date thereof 1/15/48 (month) (day) (year)
(c) Cemetery or crematory: U. S. National
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) JAN 14 1948 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1948, at 11.45a M

21. I certify that I took charge of the remains described above, held an Inspection & Ex thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to illuminating- gas.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-12-48 at 11 a. M.
(b) Where did injury occur? 13 E. Franklin St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Ingestion- illuminating gas

23. Signature: George G. Merrill M.D.
Medical Examiner.
Date signed 1/12/48

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 659004

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1239 Sargeant St.
(c) Hospital or institution: 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1239 Sargeant St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EMMA J. CONLON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed~~, or divorced: Married

6 (b) Name of husband Patrick Conlon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12th 187[illegible]

8. AGE: Years 71 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Berkley Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Wm L. Waring
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Ann V.
15. Birthplace Va.

16 (a) Informant Patrick Conlon
(b) Address 1239 Sargeant St.

17 (a) Burial (b) Date thereof 1/15/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Peters
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (date) JAN 14 1948 Washington Williams
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11, 1948, at 11.05 P.M.

21. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Subarachnoid hemorrhage

Due to Hypertension, C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Paul L. Royer M.D.
Medical Examiner.

Date signed 1-12-48

X

G53005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G53005

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Wilmont Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Payne

3 (b) If veteran, name war W. W. #1

3 (c) Social Security Account No. 220-05-4758

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Mamie V. Payne

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1894

8. AGE: Years 53 | Months 5 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Waynesboro, Pennsylvania
(Town, county and state or foreign country)

10. Usual Occupation None Maritime Guard

11. Industry or business Maritime Service

FATHER
12. Name Charles Calvin Payne
13. Birthplace Md.

MOTHER
14. Maiden Name Ellamar Manns
15. Birthplace Pa.

16 (a) Informant Mamie V. Payne
(b) Address 922 Wilmont Ct.

17 (a) Burial (b) Date thereof 1/16/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery U.S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 317 St. Paul St.

JAN 14 1948 (Date rec'd by Registrar) (Signature) for William Hill Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13 1948 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1948 to 1/13 1948, and that I last saw h[im] alive on 1/13 1948

Immediate cause of death Arteriosclerotic heart disease with
Due to left ventricular heart failure
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M.D.
Address 1400 N Caroline Date signed 1-13-48

St
X

653006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

653006 ✓ Registered No. 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12-3
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2468 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME James Patrick Fitzsimmons

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
68	2	?	hr., min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER 12. Name William Fitzsimmons
FATHER 13. Birthplace Cumberland Md
MOTHER 14. Maiden Name Annie Fogarty
MOTHER 15. Birthplace Md

16 (a) Informant Mrs. Anna Schabb
(b) Address 2468 Greenmount Ave.

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 1/15/48 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 [illegible] (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1948 at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to Jan 12 1948, and that I last saw him alive on Jan 12 1948

	Duration
Immediate cause of death Cardiac failure	12 hours
Due to Malnutrition & dehydration	2 weeks
Due to Diabetes Mellitus	?
Other Conditions Arterio sclerosis & Uremia (Include pregnancy within 3 months of death)	2

Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent M. Fogarty Jr. M. D.
Address St. Joseph's Hosp. Date signed 1-14-48

V S 150

G59007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G59007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 Webster st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Webster St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Schiner

If veteran, name war Spanish-American | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~Martin~~ Schiner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7th 1885

8. AGE: Years	Months	Days	If less than one day
62	6	6	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business Own Home

FATHER
12. Name John Schramofski
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Olinski
15 Birthplace Germany

16 (a) Informant Mrs. Florence Josephans
(b) Address 711 Ashburton St.

17 (a) Burial (b) Date thereof 1/16/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

JAN 14 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13th 1948, at 7:30 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1947 to Jan 13 1948 and that I last saw h[illegible] alive on Jan 13 1948

Immediate cause of death: acute Edema of Lungs — Duration 3 Days
Due to: Cerebral Hemorrhage — Duration 4 Hrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. Campbell M. D.
Address 1644 Hanover Date signed 1/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G59008

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 North Woodyear Street
(c) Hospital or institution: 16-W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 North Woodyear
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA JENKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife unk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 83 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Josephine E. Collins

(b) Address 710 N. Woodyear St.

17 (a) Burial (b) Date thereof Jan. 14, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington mem. park.

Location Maryland

18 (a) Funeral director A. Halstead

Address 918 David Hill Ave.

19 (a) JAN 14 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11/48 19..... at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.

Date signed 1/11/48

G59003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. G59009

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lakewood & Greene

(c) Hospital or institution: University 11-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mo

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1220 N E Culloch St (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lillie Mae Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife Clarence Wallace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24 1923

8. AGE: Years	Months	Days	If less than one day
24	8	17	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Gray Staten

FATHER 13. Birthplace North Carolina

MOTHER 14. Maiden Name Mary Jenkins

MOTHER 15. Birthplace North Carolina

16 (a) Informant Clarence Wallace

(b) Address 1220 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Maryland

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

19 (a) JAN 14 1948 (Date rec'd by Registrar) (b) Signature for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1948, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1948 to Jan 11 1948, and that I last saw her alive on Jan 11 1948

Immediate cause of death	Duration
Pulmonary tuberculosis and Uremia	
Due to Tuberculosis	
Due to	
Other Conditions Syphilis tertiary recurrent Exhaustion	

(Include pregnancy within 3 months of death)

Date of operation Dec 19 1947

Major findings of operation: abdominal adhesions; prostatectomy

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. W. Hollyswoth, MD

Address Univ Hosp Date signed 1-12-48 M. D.

VS 190

J. W. Hollyswoth

G59019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G59010

Registered No. 43a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4425 Wickford Rd.
(c) Hospital or institution: ---- 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) Life--

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Ba ltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4425 Wickford Rd.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME AMELIA F. BAILE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Henry C. Baile
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1848

8. AGE: Years	Months	Days	If less than one day
99	5	9	....hr. ....min.

9. Birthplace Ba ltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ---

FATHER
12. Name D. Weyferth
13. Birthplace Germany

MOTHER
14. Maiden Name Stenger
15 Birthplace Germany

16 (a) Informant Mrs. Virginia Bartgis
(b) Address 4425 Wickford Rd.

17 (a) Burial (b) Date thereof 1/15/48
(Burial, cremation, or removal). (month) (day) (year)
(c) Cemetery or crematory XXXXX Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa . Aves: Balto., Md.

19 JAN 14 1948 (b) Huntington Williams
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Ja n. 12. 1948 19 ; at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1946 to 1-12 1948.
and that I last saw h-- alive on 1-12-1948.

Immediate cause of death	Duration
Cerebral hemorrhage -	1 day.
Due to	
Due to Artim Selim -	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Howard F. Warner M. D.
Address 2604 Garrison Blvd Date signed 1-13-48.

X

G59011 ✓ G59011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3304 N. Hilton St.
(c) Hospital or institution: 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 YRS.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town Baltimore MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Joseph N. Neely

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife Molly C.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN. 15 1859

8. AGE: Years 88 | Months 11 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace SHREWSBURY, YORK CO. PENNA

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name SAMUEL NEELY
13. Birthplace PA.

MOTHER
14. Maiden Name LOUIS KLEINFELTER
15. Birthplace PA.

16 (a) Informant MRS. ALMA N. BAILEY
(b) Address 3304 N. Hilton St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/16/48 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS.
(b) Address North & Pa. Aves. Balto, MD

19 (a) JAN 14 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 13 1948, at 5:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from — 1948, to Jan. 13 1948, and that I last saw h. alive on Jan. 12 1948.

Immediate cause of death	Duration
(1) Bronchopneumonia	3½ days
(2) Congestive heart failure	
Due to 1:— 2- Generalized arterio-	
Due to sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. L. Hamburger Sr. M. D.
Address 1209 Eutaw Place Date signed 13 Jan '48

55012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 132

Registered No. 55012

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 426 Millington Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 Millington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Crofoot

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Annie E. Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1888

8. AGE: Years	Months	Days	If less than one day
59	3	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George W. Crofoot
13. Birthplace Md.

MOTHER
14. Maiden Name Laura B. Bell
15. Birthplace Md.

16 (a) Informant Mrs Annie Crofoot
(b) Address 426 Millington Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave.

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave

19 JAN 14 1948 (Date received by registrar) (b) Thurlington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1947 to Jan 12, 1948 and that I last saw him alive on Jan 7, 1948

	Duration
Immediate cause of death Pulmonary Tuberculosis, advanced, with repeated Hemoptysis	over 7 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Not operated
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abram Goldman M. D.
Address 206 S. Calvin St. Date signed 1/17/48

X

65013

AB-116379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 65013

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 7days?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joel Sopher

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Separated

6 (b) Name of husband or wife ?
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?-?-?

8. AGE: Years	Months	Days	If less than one day
78?			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Isaac Sopher
13. Birthplace ?

MOTHER
14. Maiden Name Fannie ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Bros.
(b) Address 2160 Eastern Place

19 JAN 14 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13- 1948, at 10.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6- 1948 to 1-13- 1948 and that I last saw h im alive on 1-13- 1948

Immediate cause of death: Coronary Occlusion — Duration 1 hr.
Due to: Arteriosclerosis
Due to:
Other Conditions: Intertrochanteric fracture left femur — 7 days
(Include pregnancy within 3 months of death)
Date of operation 1-11-48
Major findings of operation: Above fracture
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 4-1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1-6-48 at
(c) Where did injury occur? Baltimore (City or town) (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work?
(e) Means of injury Slipped, fell to floor

23. Signature Maurice M. Lasky M. D.
Address Baltimore City Hos Date signed 1-13-48

VS 190

TO BE APPROVED BY THE MEDICAL EXAMINER For C. J. Davis Howard J. Mullen for D.M.E.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G58013

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Standard Oil Co. Boston & Bean St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 West Ave. Dundalk
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK Schultz (Szulczewski)

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. 214-01-4401

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elsie Nee ,Ruth

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1890

8. AGE: Years	Months	Days	If less than one day
57 56	2	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business Standard Oil Co.

FATHER
12. Name Michael Szulczewski
13. Birthplace Poland

MOTHER
14. Maiden Name Dorothy Kapinski
15. Birthplace Poland.

16 (a) Informant Mrs. Elsie Schultz(wife.
(b) Address 1817 West Ave. Dundalk, Md.

17 (a) Burial (Burial, cremation or removal) **(b) Date thereof** 1-16-48 (month) (day) (year)
(c) Cemetery HOLY ROSARY
Location Baltimore Md.

18 (a) Funeral director George R Weber
(b) Address 705 E Lanvale st

19 (a) JAN 14 1948 (Date rec'd by registrar) **(b)** Huntington Williams

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12, 1948, at 3 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to Coronary Artery Disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Ryan M.D.
Medical Examiner.

Date signed 1-13-48

G58015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45F

Registered No. G58015

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 S.Luzerne Ave
(c) Hospital or institution: Home 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24, Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 S.Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Stanley Karcz

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-4748

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) July 11-1907

8. AGE: Years	Months	Days	If less than one day
40	6	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Checker
11. Industry or business Chevrolet Motor Corp

FATHER
12. Name Henry Andrew Karcz
13. Birthplace ?

MOTHER
14. Maiden Name Agnes Pawlak
15. Birthplace ?

16 (a) Informant Mrs. Catherine Karcz
(b) Address 713 S.Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-48 (month) (day) (year)
(c) Cemetery St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

JAN 14 1948 (Date rec'd by registrar) Huntington Williams Inc

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13th 1948, at 2m A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1947 to Jan 13 1948, and that I last saw h alive on Jan 12 1948

Immediate cause of death Carcinoma of Right Frontal Lobe of Brain

	Duration
Due to	
Due to	
Other Conditions None	Oct 1947

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation Presence of cancerous glands
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E A Schimunek M. D.
Address 842 E Eager Date signed 1-13-48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C56016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C56016

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 S. Belnord Ave
(c) Hospital or institution: Home 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 S. Belnord Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Wasowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-4242

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of wife Frances
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) June 27th (1897) 1898

8. AGE: Years	Months	Days	If less than one day
(50) 49	6	16	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Stationary Stock Room
11. Industry or business Western Electric Co

FATHER
12. Name Wladyslaw Wasowski
13. Birthplace Poland

MOTHER
14. Maiden Name Kamilia ?
15. Birthplace Poland

16 (a) Informant Mrs. Frances Wasowski
(b) Address 626 S. Belnord Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-48 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George R Weber
(b) Address 705 South Ann Street

19 JAN 14 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12th 1948, at 8th P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 19 48 to 1/12 19 48, and that I last saw him alive on 1/11 19 48

Immediate cause of death: Coronary occlusion

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. M. Gabriel F. Nowakowski M. D.
Address 1016 S. East Ave. Date signed 1/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

90127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 90127

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 GROVE ST
(c) Hospital or institution: ST JOSEPH'S HOSP 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) 77-9-23

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 E. BIDDLE ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MRS EMMA M. GRAHAM

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-19-70

8. AGE: Years	Months	Days	If less than one day
77	9	23	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation HOUSE
11. Industry or business

FATHER 12. Name Paris Baker
13. Birthplace Mass

MOTHER 14. Maiden Name Celia A. Brewer
15. Birthplace Md.

16 (a) Informant Mrs Regina Graham
(b) Address 912 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wredfield
(b) Address 900 E. Baltimore St

19 (a) JAN 14 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12-48 1948 at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1948 to 1-12 1948. and that I last saw her alive on 1-12 1948.

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration
Due to PULMONARY EMBOLUS
Due to FRACTURE L. FEMUR
Other Conditions HYP CARDIOVASC DIS (Include pregnancy within 3 months of death)
Date of operation 1-10-48
Major findings of operation: COMM FRACT L FEMUR
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT 10/1
(b) Date of occurrence 1-6-48 at 10 AM
(c) Where did injury occur? BALTO. MD. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? NO
(e) Means of injury FALL ON FLOOR
23. Signature John B Weller M.D. M. D.
Address Date signed

N. J. Marcin, M.D. To be approved by Med. Exam.

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8.3a

Registered No. C59018

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1607, 23rd St
(b) Street address St. Paul & 23rd. Stree
(c) Hospital or institution:
Dr. Beaks Clinic 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Northway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNIE MORRIS GARDNER RIES

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dr. August Ferdinand

6 (c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): April 1, 1884

8. AGE: Years: 63 | Months: 9 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Edgewood, R.I.
(Town, county, and state)

10. Usual Occupation:

11. Industry or business: Housewife

FATHER
12. Name: Michael Morris Gardner
13. Birthplace: York, Pa.

MOTHER
14. Maiden Name: Sarah Bratten
15. Birthplace: Pa.

16 (a) Informant: Dr. A.F.Ries
(b) Address: 302 Northway

17 (a) ENTOMBMENT (Burial, cremation, or removal) (b) Date thereof 1/15/48 (month) (day) (year)
(c) Cemetery or crematory: GREENMOUNT CEMETERY
Location: BALTIMORE, MD.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) JAN 14 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12 1948 at 8:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 to Jan 12 1948 and that I last saw h er alive on Jan 12 1948

Immediate cause of death: Cerebral Hemorrhage — Duration: 10 hrs

Due to: Cerebral arteriosclerosis — Indefinite

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury: —

23. Signature: Nathaniel McBeth M.D.

Address: Date signed

VS 150

G59019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59019 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1242 Bonaparte Avenue
(c) Hospital or institution: 9-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1242 Bonaparte Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWIN DIXON

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Fannie R. Dixon
6 (c) If alive, give age 85 years
7. Birth date of deceased (mo., day, yr.) Sept. 14, 1857

8. AGE: Years	Months	Days	If less than one day
90	3	27 (26)	hr. min.

9. Birthplace Snow Hill, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business U.S. Custom Service

FATHER
12. Name Edwin Dixon
13. Birthplace Maryland

MOTHER
14. Maiden Name Priscella Knox
15. Birthplace Maryland

16 (a) Informant Mrs. Fannie R. Dixon
(b) Address 1242 Bonaparte Avenue

17 (a) Burial (b) Date thereof 1/14/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 14 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1948, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 10 1948 and that I last saw h[illegible] alive on Jan 10 1948.

Immediate cause of death	Duration
Cardiac Vascular Disease	2 yrs
Due to	
Due to	
Other Conditions Cerebral Arteriosclerosis	6 mo

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fritz S. Shumsey M. D.
Address 2700 Hartford Rd Date signed January 13 48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

250020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 250020

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 Beaumont Ave.
(c) Hospital or institution: ***** 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) **
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Beaumont Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Frame

3 (b) If veteran, name war ****
3 (c) Social Security Account No. ***

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Nathan P. Frame
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years about 86 | Months ** | Days ** | If less than one day ... hr. ... min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation none

11. Industry or business ****

FATHER
12. Name Clinton Prestone
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Anna ?
15. Birthplace Pennsylvania

16 (a) Informant Mrs Helen A. Thompson
(b) Address 909 Beaumont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City

18 (a) Funeral director A.W. Mears and Son
(b) Address 805 N. Calvert St.

19. JAN 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1947 to June 13 1948, and that I last saw h[illegible] alive on June 13 1948

Immediate cause of death ... Duration

Valvular Heart disease

Due to ...

Due to ...

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ...
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature Jacob Foster M. D.
Address 1825 N. Broadway Date signed 1/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59021 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-2
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528 Johannsen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSIE JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
53 52			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Eliza Coasey
(b) Address 201 - 12th St., N.W. Wash., D.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 14 48 (month) (day) (year)

(c) Cemetery or crematory
Location Washington, D.C.

18 (a) Funeral director R. Goldsmith Halstead
(b) Address 1 & 3 Bates Court

19 (a) Jan 14 1948 (Date received by local registrar) (b) Washington, D.C.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12, 1948, at 6 a.m. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congesting Heart
Disease
Due to Arteriosclerotic C.V.
Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury a.m. M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyer M.D.
Medical Examiner.
Date signed 1-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. 659033

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 W. Baker Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days) 32 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 W. Saratoga Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Phyllis Williams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Ruxton Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1915.

8. AGE: Years	Months	Days	If less than one day
32	2	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ralph Campbell
13. Birthplace Md.

MOTHER
14. Maiden Name Washington
15. Birthplace Md.

16 (a) Informant Husband
(b) Address 623 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director Mrs. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) JAN 14 1948 (Date rec'd by registrar) (b) [illegible] Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1948 at 8:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1947, to Jan. 10 1948, and that I last saw her alive on Jan. 10 1948.

Immediate cause of death	Duration
Toxemia	
Due to Carcinoma of the right tonsil with metastasis	5 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Steiner M. D.
Address 1214 Eutaw Place Date signed 1/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓

Registered No. 59023

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1706 Woodyear Pl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARA GREEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	W

6 (b) Name of husband or wife Chester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 - - 1887

8. AGE: Years	Months	Days	If less than one day
60	4		hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER
12. Name James Bames
13. Birthplace Md

MOTHER
14. Maiden Name Mary -
15. Birthplace Md

16 (a) Informant Cora Gordon
(b) Address 523 W. Lafayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Lee H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) JAN 14 1948 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 JAN 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 JAN 1948 to 12 JAN 1948, and that I last saw her alive on 12 JAN 1948.

Immediate cause of death	Duration
SHOCK & RESPIRATORY FAIL.	
Due to DIABETIC COMA	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R D Bames M.D.
Address Univ. Hospital Date signed 1/13/48

For S. H. Davis, M.D.
Howard J. Hopkins, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

Registration No. 059024

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2438 Etting St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Lee

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Hughe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/13/1901

8. AGE: Years	Months	Days	If less than one day
46	2	29	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Simon Bagwell
13. Birthplace Va

MOTHER
14. Maiden Name Katherine —
15. Birthplace Va

16 (a) Informant Hugh H. Lee
(b) Address 2438 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. E. Kehoe
(b) Address 1303 Pennsylvania Ave

19 (a) JAN 14 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11 1948, at 9:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1948 to 1/11 1948, and that I last saw h[illegible] alive on 1/10 1948.

Immediate cause of death	Duration
Renal Failure	24 hrs
Due to Hypertensive CVD	
Due to Arteriosclerosis	
Other Conditions Chr. Nephritis	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R G Neubauer M. D.
Address University Date signed 1/14/48

Hosp. 93)

659025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132B

659025 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: Sorrells Baltimore General Hosp
(d) Length of stay in hospital or inst. (if not a resident give number of days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Fielddea Et
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Fulton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Miss MARTHA CERNE

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-20-5712

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2, 1925

8. AGE: Years	Months	Days	If less than one day
22	2	9 10	hr. min.

9. Birthplace Steyer, Maryland (Town, county, and state)
10. Usual Occupation Student
11. Industry or business None

FATHER
12. Name Joseph Cerne
13. Birthplace Austria

MOTHER
14. Maiden Name Rosie Selak
15. Birthplace Austria

16 (a) Informant Austine Hoy (Sister)
(b) Address Same

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1 15 48 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 (a) JAN 14 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12- 1948 at 8 Da M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31- 1948 to 1-12 1948, and that I last saw her alive on 1-12- 1948

	Duration
Immediate cause of death: Respiratory failure	
Due to: Acidosis	2 wks
Due to: Hypoproteinemia, Anemia Colitis	6 yrs 2 wks
Other Conditions: Acute laryngotracheo bronchitis (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation: Bleeding duodenal ulcer	
of autopsy: Duodenal ulcer	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert M. Carouge M. D.
Address 6226 Everall Ave Date signed 1-12-48

VS 150

Orfice copy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 65038

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 N. Luzerne Ave
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Luzerne Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Vacek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John Vacek

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16 1858

8. AGE: Years 89 | Months | Days 25 | If less than one day ____hr. ____min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Buzick
13. Birthplace Bohemia

MOTHER
14. Maiden Name Mary Kraus
15. Birthplace Bohemia

16 (a) Informant Clem German
(b) Address 432 N. Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Brockhan
(b) Address 900 N. Eutaw St

19. JAN 14 1948 (Date rec'd by Registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1948; at 2:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1938 to January 11, 1948 and that I last saw her alive on January 11, 1948

Immediate cause of death Cerebral Hemorrhage — Duration 1 Day

Due to Cardio-Vascular Hypertensive disease — 10 years

Due to Arteriosclerosis — 10 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Dausch M. D.
Address 1 W. Preston St Date signed 1/14/48

V S 150

X

659027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 659027

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 N. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) T
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N. Collington (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Vachal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Vachal

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Dec 16, 1885

8. AGE: Years 62 | Months 4 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name: Joseph Lusek
13. Birthplace: Bohemia

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Bohemia

16 (a) Informant: John Vachal
(b) Address: 905 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 16 1948 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balt Md

18 (a) Funeral director: Frank Crockford
(b) Address: 900 N. Liberty St

19 JAN 14 1948 (Date rec'd by Registrar) (Signature) Functional for Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1948, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1946 to Jan 12 1948, and that I last saw h[illegible] alive on Jan 6 1948

Immediate cause of death: Hypostatic Pneumonia

Due to: Paranoia & Alcoholism

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
1/9/48
1/946

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: William J. Rauch M.D.
Address: 501 N Kenwood Ave Date signed 1/13/48

G5028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G5028 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 W. 23rd St, 17-1
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 W. 23rd. Ste. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edith Hall,

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James Hall
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1909

8. AGE: Years	Months	Days	If less than one day
38	5	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name John Thomas.
13. Birthplace Calvert Co., Md.

MOTHER 14. Maiden Name Elizabeth Ross.
15. Birthplace Calvert Co., Md.

16 (a) Informant James W. Thomas.
(b) Address 110 W. 23rd. Ste

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Wm. Kater R. Williams
(b) Address 322 N. Schroeder St

19 JAN 14 1948 (Date rec'd by registrar) Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1948, at 7:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1948 to Jan 13 1948 and that I last saw her alive on Jan 13 1948

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Johnson M. D.
Address 2329 Garrison Blvd. Date signed Jan 14 1948

X

(55) 063 JL - 94182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 550,039

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 826 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Bevins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife Hattie (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1867

8. AGE: Years	Months	Days	If less than one day
80 ?			hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Dennis
13. Birthplace ?

MOTHER
14. Maiden Name Susan ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JUN 14 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1948, at 7pm M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945 to Jan. 9 1948, and that I last saw h. alive on Jan. 9 1948

Immediate cause of death — Duration

Heart Failure

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Marked Gen. Arteriosclerosis Pathogenesis of Heart

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm R. Hearbarger M. D.
Address Balto City Hosp. Date signed 1-10-48

C55030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13

Registered No. C55030

GM. 113386

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: B'lto. City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Most Of Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 662 Bradley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marietta Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8 - 1914

8. AGE: Years	Months	Days	If less than one day
33	5	4	hr. min.

9. Birthplace VA. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Stuard Williams
13. Birthplace ?

MOTHER
14. Maiden Name Ruth Tanner
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 14 1948 (Date rec'd by registrar) (Funeral Director or Address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12 - 48, at 12.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 27 1947 to Jan. 12 - 1948, and that I last saw her alive on Jan. 12 - 1948

Immediate cause of death Pulmonary Tuberculosis — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. W. Bennett

Address Baltimore City Hospital Date signed 1/13/47 (M. D.)

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 65[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 412 N. Stricker St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Gillian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C.	Widow

6 (b) Name of husband or wife Carrie Gillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1890

8. AGE: Years	Months	Days	If less than one day
56	10	7	hr. min.

9. Birthplace Newberry S.C.
(Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Mack Gillian
13. Birthplace Newberry, S.C.

MOTHER
14. Maiden Name Martha
15. Birthplace Newberry, S.C.

16 (a) Informant Rosa Brown
(b) Address 412 N. Stricker St.

17 (a) Burial (b) Date thereof Jan 16 1898
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location

18 (a) Funeral director Mrs Katie R. Gilliam
(b) Address 422 E. Lanvale St.

19 (a) JAN 14 1898 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 1898, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Fulbright M.D.
Medical Examiner.
Date signed 1/13/98

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59032

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Mulligan Court.
(If rural give location)
(e) Citizen of foreign country? Milliken (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD S WASHINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-3820

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1917

8. AGE: Years	Months	Days	If less than one day
30	6		hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Richard Washington
13. Birthplace Va

MOTHER 14. Maiden Name Lucy Redmond
15. Birthplace Va

16 (a) Informant Lucy Washington / mother
(b) Address 1421 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem Co
Location Pikesville Md

18 (a) Funeral director Robert E. Waller
(b) Address 1615 McCulloh

19 (a) JAN 14 1948 (Date rec'd by registrar) (b) Huntington Mills, Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12, 1948, at 4.50 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If death from external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur in home, on farm, industrial place, in public place? While at work?

(d) Means of injury

Signature George S. Merrill M.D.
Medical Examiner.

Date signed 1-13-48

G59033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G59033

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 McElderry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 McElderry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Cornish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife J. F. Cornish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21-1862

8. AGE: Years	Months	Days	If less than one day
85	3	21	hr. min.

9. Birthplace Dorchester Co Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Irvin Manor
13. Birthplace Md

MOTHER 14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Martha Brown
(b) Address 1613 McElderry St

17 (a) Burial (b) Date thereof Jan 15-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem
Location Balto Md

18 (a) Funeral director Patrick McGuinness
(b) Address 1515 McElderry St

19 JAN 14 1948 (Date rec'd by registrar) Huntington Nelligan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1948 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16th 1947 to Jan 12th 1948, and that I last saw h alive on Jan 12 1948

Immediate cause of death Cerebral hemorrhage — Duration 2 days

Due to Myocarditis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Lefand M. D.
Address 824 N. Broadway Date signed 1/14/48

VS 150

G59034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

G59034 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N. East Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Alfonse Tyszko

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-30-7035

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/14/26

8. AGE: Years 21 | Months 1 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Md Drydock

FATHER 12. Name Alexander Tyszko
13. Birthplace Balto Md

MOTHER 14. Maiden Name Helen Wittkofsky
15. Birthplace Balto. Md.

16 (a) Informant Alexander Tyszko
(b) Address 10 - N. East ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

JAN 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 19 48 at 5 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6/48 19 to 1/12/48 19 and that I last saw h.... alive on 1/12/48 19

Immediate cause of death	Duration
Massive Pulmonary Embolism	12
Due to Acute Appendicitis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1/6/48

Major findings of operation: Acute Suppurative Appendicitis

Findings of autopsy: Pulmonary Embolism

PHYSICIAN
Underline the cause which should be charged with the death.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Bailey M. D.
Address 1400 N Caroline Date signed 1/12/48

X

G59035 ✓ G59035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 49a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Charles St.
(c) Hospital or institution: Doctors Hospital 20 N
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 W. Baltimore (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eva E. McElfish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Single.

6 (b) Name of husband or wife "

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23. 1912

8. AGE: Years	Months	Days	If less than one day
35	5	20	hr. min.

9. Birthplace Cumberland - Md. (Town, county, and state)
10. Usual Occupation Beauty Parlor Operator
11. Industry or business Frenchs - Beauty Shop

FATHER
12. Name Perry G. McElfish
13. Birthplace Maryland

MOTHER
14. Maiden Name Wealthy C. Buoy
15. Birthplace Maryland

16 (a) Informant Wealthy C. McElfish
(b) Address 1901 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 15 Jan 48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn Md.

18 (a) Funeral director F. B. Wippert. Son
(b) Address 1300 Eutaw Place.

19 (a) (b) (Signature of registrar)

JAN 19 1948

VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12. 1948 at 12 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1947 to Jan 12 1948. and that I last saw h alive on Jan 10 1948.

Immediate cause of death Coronary Thrombosis
Contributory
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Shortt M. D.
Address 2302 Eutaw Pl. Date signed 1/13/48

X

G59036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G59036

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address GREEN & Redwood Dist
(c) Hospital or institution: University Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2000 Letitia Ave
(If rural give location)
(e) Citizen of foreign country? Na (Yes or No)
If yes, name country

3 (a) FULL NAME John W. C. Cooper / John WC Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-8059

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary Jr.

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Mar 21-1885

8. AGE Years	Months	Days	If less than one day
62	9	20	hr. min.

9. Birthplace Baltimore Co. Md
(Town, county, and state)

10. Usual Occupation Receiving Clerk

11. Industry or business Food Fair

FATHER
12. Name John Wesley Cooper
13. Birthplace Pa.

MOTHER
14. Maiden Name Ruth Ann Baker
15. Birthplace Pa.

16 (a) Informant Mary Ann Cooper (wife)
(b) Address 2000 Letitia Ave.

17 (a) Burial (b) Date thereof 14-Jan-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore - Md

18 (a) Funeral director F. D. Weyforth & Son
(b) Address 1300 Eutaw Place 17

(a) 14 1948 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1948, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dr. Jubrinski M.D.
Medical Examiner.
Date signed 1/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GM. 116218 G58037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G58037 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals. 52
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Forrest St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: August C. Wolf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22-1863

8. AGE: Years 84 ? Months 1 Days 19 If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Wolfe
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Anna
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1-15-48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Holy Redeemer
Location Md.

18 (a) Funeral director L. J. Rusk
(b) Address 5305 Ithsford Road

19 (a) Date 1948 (b) Huntington Williams
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10-48 1948, at 6.45A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 30 1947, to Jan. 10- 1948, and that I last saw h im alive on Jan. 10- 1948

Immediate cause of death	Duration
Arteriosclerotic gangrene of left foot	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1-8-48

Major findings of operation: Gangrene of left foot

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lang, M.D. M. D.
Address Baltimore City Hosp Date signed 1-13-48

X

G59038 JL-59995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59038 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 22-1
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Dover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Waxter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15.1868

8. AGE: Years	Months	Days	If less than one day
79	3	30	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Gus Waxter
13. Birthplace Germany

MOTHER
14. Maiden Name Mary
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director L. J. Luck
(b) Address 5305 Belford Road

19 (a) (Date rec'd by registrar) (Signature) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1948, at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1940, to Jan. 13 1948, and that I last saw h im alive on Jan. 13 1948.

Immediate cause of death Cerebro-vascular accident. — Duration

Due to Generalized arterio-sclerosis & Arteriosclerotic

Due to H. Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Forbes, Jr. M.D.
Address Balto City Hosps Date signed 14 Jan 48

JAN 14 1948

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59039 — BALTIMORE CITY HEALTH DEPARTMENT — G59039

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3001 Herbert St.
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Herbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME William E. Jackson

3 (b) If veteran, name war: W.W. 1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Lillian D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1889

8. AGE: Years 58 59 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Thomas A. Jackson
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Susan Effie Parker
15. Birthplace Carroll Co., Md.

16 (a) Informant Mr. Miles Jackson
(b) Address 1922 N. Forest Park Ave.,

17 (a) Burial (b) Date thereof 1-15-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory XXX New Balto. National
Location Baltimore, Md.

18 (a) Funeral director S. Howard Storey
(b) Address 3207 W. North Ave.,

JAN 14 1948

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13, 1948, at 8 a. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Carcinoma of lung.
Due to Pulmonary tuberculosis
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/13/48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G59040
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 W. 36th St
(c) Hospital or institution:
13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 W. 36th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Arvanites.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Evangeline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years: 62. | Months | Days | If less than one day: hr. min.

9. Birthplace: Greece
(Town, county, and state)

10. Usual Occupation: Cook.

11. Industry or business

FATHER
12. Name: John Arvanites
13. Birthplace: Greece.

MOTHER
14. Maiden Name
15. Birthplace: Greece.

16 (a) Informant: Wife.
(b) Address: 600 W. 36th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-48 (month) (day) (year)
(c) Cemetery or crematory: Greek Cem
Location: Windsor Mill Rd

18 (a) Funeral director: Lambos Inc
(b) Address: 440 E. North ave

19 (a) (Date rec'd by registrar) (b) Registrar

Allvd Jan 14 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1948 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1947 to Jan 13 1948. and that I last saw h[illegible] alive on Jan 13 1948.

Immediate cause of death: Cerebral Vasc accident — Duration: 1 day

Due to: Hypertensive Cardiovascular Disease — Duration: [illegible] years

Due to:

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Leonard Wallenstein M. D.
WALLENSTEIN

Address 598 W 36th St Date signed Jan 20 1948

937 1838

59071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106c

Registered No. G59071

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Dundalk Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Barronway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jodie Sykes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-31-47

8. AGE: Years | Months 4 mos | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jo-die Sykes
13. Birthplace N.C.

MOTHER 14. Maiden Name Frances Moss
15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 3 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 14 1948 (Date rec'd by registrar) (b) Per Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1947, to Dec. 30 1947, and that I last saw h[illegible] alive on Dec. 30 1947.

	Duration
Immediate cause of death Respiratory failure due to aspiration	Immediate
Due to Cong. obstructive anomaly of larynx - [redacted]	4 mos.
Other Conditions Laryngo-tracheo-bronchitis - chronic	2 mos.
Laryngo-Tracheobronchitis	

(Include pregnancy within 3 months of death)
Date of operation 10-21-47
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Caffey Jr. M. D.
Address The Johns Hopkins Hosp. Date signed 12-30-47

G59042

BALTIMORE CITY HEALTH DEPARTMENT

TN. 116192

CERTIFICATE OF DEATH 937

G59042 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 3-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Milhiser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31/1892

8. AGE: Years	Months	Days	If less than one day
55	5	1	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lewis (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Gerrie (or Gennie ? (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 1/26/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location [redacted] JAN 9, 1948

18 (a) Funeral director Commissioner of Health
(b) Address Jack Lewis, Inc.

19 JAN 14 1948 [signature]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1st. 1948, at 4.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29th 1947 to Jan. 1st 1948, and that I last saw him alive on Jan. 1st 1948

Immediate cause of death	Duration
Myocardial infarction, acute, probable	minutes
Due to Hypertensive Cardio-vascular Disease	?
Due to	
Other Conditions Cellulitis, right leg	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M.D.
Address Baltimore City Hosp Date signed 1-5-48

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59043 — BALTIMORE CITY HEALTH DEPARTMENT — G59043 Registered No.

CERTIFICATE OF DEATH

124a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kentucky (b) County
(c) City or town Middlesboro (If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Lothbury Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ike Sharp

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Nellie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/27/1898

8. AGE: Years	Months	Days	If less than one day
49	9	17	hr. min.

9. Birthplace Kentucky (Town, county, and state)
10. Usual Occupation Dry - Cleaner
11. Industry or business

FATHER 12. Name Meel Sharp
13. Birthplace Tenn.

MOTHER 14. Maiden Name Dara Edwards
15. Birthplace Tenn.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/48 (month) (day) (year)
(c) Cemetery or crematory Middlesboro.
Location Bell Co. Kentucky

18 (a) Funeral director Wm Cox Jr.
(b) Address 1217 E Baal St.

19 (a) (Date received by registrar) (b) Registrar

JAN 14 1948 — Registrar — VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1948, at 9 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1947, to Jan 14 1948, and that I last saw him alive on Jan 14 1948

Immediate cause of death	Duration
Cholemia	
Due to Cancer of Liver	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Cancer of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H M Markley M. D.
Address Johns Hopkins Hosp. Date signed 1-14-48

X

Dr. Frederick
2116 W. Pratt St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 6550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 W. Lindsor Ave
(c) Hospital or institution:
Lindsor Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 W 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Columbus H. Bromwell.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Carrie V. Bromwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1868

8. AGE: Years	Months	Days	If less than one day
79	3	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Arthur C. Bromwell.
(b) Address 815 W 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Road.

18 (a) Funeral director Thanhouser & Donovan
(b) Address 3615-17 Harford Ave

19 (a) JAN 14 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1947 to Jan 12 1948. and that I last saw him alive on Jan 10 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Thrombosis	
Due to Arteriosclerotic Cardio-Vascular disease	
Other Conditions Fractured Pelvis Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 13/5
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/26/47 at 10a M
(c) Where did injury occur? 815 W 33rd St Balto MD
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? No
(Specify type of place)
(e) Means of injury Fell to floor.

23. Signature R. Frederick
Address 2116 W. Pratt St Date signed 1/14/48 M D

For Dr. F. Dr. Frederick to Howard J. Smith, M.D.

VS 130

659045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 659045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 W. Lombard Street
(c) Hospital or institution: 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 W. Lombard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Kuhl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John E. Kuhl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1890

8. AGE: Years	Months	Days	If less than one day
57	11	26	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Bush
13. Birthplace Relay, Maryland

MOTHER
14. Maiden Name Clara M. Williams
15. Birthplace Baltimore, Maryland

16 (a) Informant James E. Kuhl
(b) Address 222 S. Collins Avenue

17 (a) burial (b) Date thereof 1/17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Jan 15 1948 (b) Huntington Williams M.D. Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1948, at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to Jan 14 1948, and that I last saw her alive on Jan 13 1948.

Immediate cause of death: Coronary Thrombosis — Duration 2 days.
Due to
Due to
Other Conditions: Chronic nephritis & hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Nathan Racusin
Address 206 S. Gilmor St Date signed 1-14-48 M.D.

Nathan Racusin 94a

659046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

659046 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Uf
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 647 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter H. Moore

3 (b) If veteran, name war

3 (c) Social Security Account No. 236-

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of ~~husband~~ wife Edith Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6th 1884

8. AGE: Years	Months	Days	If less than one day
63	7	7	hr. min.

9. Birthplace Bluefield W. Va. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Self

FATHER
12. Name (Unknown) Moore
13. Birthplace W. Va.

MOTHER
14. Maiden Name " Whittaker
15. Birthplace W. Va.

16 (a) Informant Walter H. Moore
(b) Address 647 W. Lexington St.

17 (a) Removal (b) Date thereof 1/15/48
(~~Burial, cremation,~~ or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Bluefield W. Va.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 15 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13 1948, at 6 40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1/14/48

VS 151

G59047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G59047

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 E. Moyer St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE C. NESS

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-8308

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife Ida Ness
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) June 25 1878

8. AGE: Years	Months	Days	If less than one day
69	6	18	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Handyman
11. Industry or business Self

FATHER
12. Name George C. Ness Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Hester A. ?
15 Birthplace Md.

16 (a) Informant John R. Ness
(b) Address 2938 Cornwall Rd.

17 (a) Burial (b) Date thereof 1/17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 E. Paul St.

19 (a) JAN 15 1948 Huntington Williams, M.D.
(Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1948 at 4 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1948 to Jan 13 1948 and that I last saw h[im] alive on Jan 13 1948

Immediate cause of death	Duration
Bronchopneumonia	
Bilateral	
Due to	
OTHER CONDITIONS:	
~~Due to~~ Bronchogenic Carcinoma	
Other Conditions Pulmonary Edema due to Arteris-Sclerotic Heart dis.	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Allan J. Wolinsky M.D.
Address Sinai Hosp. Date signed 1-13-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

659048 CERTIFICATE CORRECTED 3-12-48 ✓ 124a

Registered 659048

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ala (b) County
(c) City or town Tuscaloosa
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Burwell K. (Burrell) BRADFIELD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 56 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Bradfield
13. Birthplace Alabama

MOTHER
14. Maiden Name Elizabeth Lewis Bradfield
15. Birthplace Alabama

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 1/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Tuscaloosa
Location Ala

18 (a) Funeral director Williray Cook Inc.
(b) Address 1217 St. Paul St.

19 JAN 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 1948, at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1948 to 1-14 1948, and that I last saw her alive on 1-14 1948.

Immediate cause of death	Duration
Hemorrhage	
rupture of	
Due to Esophageal Varices	
Due to Laennec Cirrhosis of Liver (Possible Carcinoma)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: None

of autopsy: To be performed

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Manner of injury

23. Signature H. L. Jamison. M.D.

Address Univ. Hosp. Baltimore Date signed 1-14-48 M.D.

VS 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SC - C 79027

659049 GR. 116079

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

Registered No. 659049

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Webb ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Leroy Arnold Waters

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23 - 1947

8. AGE: Years	Months	Days	If less than one day
		17	hr. min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leroy Waters
13. Birthplace Chester PA.

MOTHER
14. Maiden Name Pearl ?
15. Birthplace Balto. MD.

16 (a) Informant Records Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 1-13 - 48
(Burial, cremation, or removal) (month) (day) (year)
(c) [redacted] or crematory B.C.H. At 9.00 Am
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) Jan 15 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 10 -- 1948, at 10.55PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 - 1947 to Jan. 10 1948 and that I last saw him alive on Jan. 10 - 1948

Immediate cause of death	Duration
Prematurity	18 days
Due to	
Due to	
Other Conditions Diarrhea	7 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Prematurity, Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Bal. City Hosp. Date signed 13 Jan 48

159

659050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 659050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 Lynchester Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Becker, Anna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hillel Rosenzweig
13. Birthplace Russia

MOTHER
14. Maiden Name Rena
15. Birthplace Russia

16 (a) Informant Mrs Bertha Engelman
(b) Address 3524 Lynchester Road

17 (a) Burial (b) Date thereof 1-15-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jacob Lewis Inc
(b) Address 2160 Eutaw Place

19 (a) JAN 15 1948 (b) Huntington Williams
(Date rec'd by registrar)

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Jan 1948 at 11½ AM

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Jan 1948 to 13 Jan 1948, and that I last saw her alive on 13 Jan 1948

	Duration
Immediate cause of death: Pulmonary edema	15 hrs
Due to: Arteriosclerotic heart disease	unknown
Due to:	
Other Conditions: Glaucoma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin M. Davis M. D.
Address Sinai Hospital Date signed 13 Jan 48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 659051

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3027 E Monument Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3027 E. Monument Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Hagen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/1/1858

8. AGE: Years 89 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name Charles Fay

FATHER 13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Elizabeth Schreiber

MOTHER 15. Birthplace Baltimore, Maryland

16 (a) Informant Charles Hagen

(b) Address 3027 E. Monument Street

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-16-48 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location North Avenue & Rockrose

18 (a) Funeral director Frederick D. Miller, Inc.

(b) Address 3012 E. Monument St. Baltimore, Md.

19 JAN 15 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13/48 19 , 2:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis M.D. (Medical Examiner.)

Date signed 1/13/48

VS 151

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 550052

~~550052~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) 5 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Poplar Grove St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary A. Hutson
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Isaac J. Hutson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13th 1867

8. AGE: Years	Months	Days	If less than one day
80	9	1?	hr. min.

9. Birthplace Wisconsin
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Fredk. Welsch
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Goldtz
15. Birthplace Germany

16 (a) Informant Clara Mehan
(b) Address 1312 Poplar Grove St

17 (a) Burial (b) Date thereof 1 12 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Rd.

19 (a) JAN 15 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Jan 14 1948 and that I last saw her alive on Jan 14 1948.

Immediate cause of death	Duration
Chronic cardio renal disease	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ernest H. Palm M. D.
Address 730 Poplar Gr Date signed 1/14/48

VS 150

659053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 659053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3115 Belmont Ave.,
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3115 Belmont Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine L. House

3 (b) If veteran, name war ----

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mr. Michael S. House
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 5, 1852

8. AGE: Years 95 | Months 9 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Samuel Frommerfelt
13. Birthplace Canada

MOTHER
14. Maiden Name Lavinia Morningstar
15. Birthplace Canada

16 (a) Informant Mr. Samuel M. House
(b) Address 3115 Belmont Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 JAN 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 11.00

20. DATE OF DEATH January 13, 1948, at p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1948 to Jan 13, 1948 and that I last saw him alive on Jan 13 1948

Immediate cause of death	Duration
Cardiac Thrombosis	10 d
Due to Essential Hypertension	1 yr
Due to Uremia Sclerosis	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. T. Hawkins
Address 1 E Randall St Date signed 1/14/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 659054

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 21 S Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 S. Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Clarke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife. Edward M. Clarke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 1870

8. AGE: Years 77 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Dorsey

13. Birthplace Maryland

14. Maiden Name Not Recorded

15. Birthplace

16 (a) Informant Jane O'Farrell Clarke

(b) Address 21 S. Linwood Ave, Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Fredrick Rd

18 (a) Funeral director John A. Moran

(b) Address 3006 E. Balt. St.

19 JAN 15 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 13 1948, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 6 1948 to JAN 13 1948, and that I last saw her alive on JAN 13 1948.

	Duration
Immediate cause of death CEREBRAL HEMORRHAGE	7 DAYS
Due to HYPERTENSIVE-CARDIO VASCULAR-RENAL DISEASE	4 YRS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F Kernaghan M.D.

Address 3014 W Fredrick Date signed 1-14-48 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G59055

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 Wilmer Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elijah WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-8446

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles White
13. Birthplace Va

MOTHER
14. Maiden Name Laura White
15. Birthplace Va

16 (a) Informant Mrs. Mary White

(b) Address 1038 Wilmer St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location Baltimore - Md.

18 (a) Funeral director Mrs. Frances A. Jennings

(b) Address 578 W. Biddle St.

19 (a) JAN 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1948, at 12:50 PM

21. I certify that I took charge of the remains described above, held an Inspection + Inq (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh A. Merrill M.D. Medical Examiner.

Date signed 1/12/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 05306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 738 Bradley Se-
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 738 Bradley Se- (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosa Hawkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1858

8. AGE: Years 5-9 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Lancaster S. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER | FATHER

12. Name Henry Wheatherspoon

13. Birthplace Lancaster S. C.

14. Maiden Name Mary Kilgo

15. Birthplace Lancaster S. C.

16 (a) Informant Geneva Young

(b) Address 709 Bradley Se-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley Ave

19 (a) (Date received) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Jan 1948, at 8 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Jan 1948 to 10 Jan 1948 and that I last saw h[illegible] alive on 10 Jan 1948.

Immediate cause of death: Congestive Heart Failure — Duration

Due to hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanford C. Inman Jr. M. D.

Address 2309 Druid Hill Date signed 1-13-48

X

059057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. 059057

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2329 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Division St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary B. Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5 Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Massie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1870

8. AGE: Years 52 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Gloucester Co. Va (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER 12. Name John Bright
13. Birthplace Gloucester, Va.

MOTHER 14. Maiden Name Fannie Smith
15. Birthplace Gloucester, Va

16 (a) Informant Beatrice Bright
(b) Address 2329 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-1948 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Gloucester, Va

18 (a) Funeral director James George H. Stallard
(b) Address 1631 Druid Hill Ave. (Signature of licensed undertaker or agent)

19 JAN 15 1948 (Registered by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13 1948, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1948, to 1/13 1948, and that I last saw h[illegible] alive on 1/13 1948

	Duration
Immediate cause of death Chr. Nephritis +	
Due to Uremia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burl Rutter M. D.
Address 2139 Druid Hill Ave Date signed 1/13/48

VS 150

659058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road.
(c) Hospital or institution: Ashburton Nursing Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Hilton Road.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES STEELE FRIEDMAN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Max Friedman.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1877.

8. AGE: Years	Months	Days	If less than one day
70	8	14	13 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Louis Steele,
13. Birthplace Germany.

MOTHER
14. Maiden Name Clara Brandt,
15. Birthplace Germany.

16 (a) Informant Mrs. Charles Friedman,
(b) Address 2513 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.15.48.
(month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Harris Levin Funeral Home
(b) Address 1902 Eutaw Place.

19 (a) JAN 15 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13th. 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Jan. 13 1948, and that I last saw h. alive on Jan. 1 1948.

	Duration
Immediate cause of death: Cerebral hemorrhage	1 day
Due to: Hypertension, Arteriosclerosis	5 years
Due to:	
Other Conditions: Diabetes mellitus (Include pregnancy within 3 months of death)	5 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Alan Bernstein M. D.
Address 1109 N Calvert Date signed 1/13/48

83a

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

659059

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME DR. EUGENE J. LEOPOLD.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sadie H.F.Leopold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1879.

8. AGE: Years	Months	Days	If less than one day
68	1	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Physician.
11. Industry or business

FATHER
12. Name Joseph Leopold,
13. Birthplace Germany.

MOTHER
14. Maiden Name Rosa Weiller,
15. Birthplace Germany.

16 (a) Informant Mrs. Sadie H.Frank Leopold
(b) Address 200 W. Lafayette Ave.

17 (a) Burial (b) Date thereof 1.16.48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Harris Levering & Levy
(b) Address 1902 Eutaw Place.

19 (a) JAN 15 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1948 at 9 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1948 to Jan 14 1948.
and that I last saw h alive on Jan. 10 1948

Immediate cause of death
Coronary occlusion
Due to Arteriosclerosis

Due to –

Other Conditions –
(Include pregnancy within 3 months of death)

Date of operation –
Major findings of operation –
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Zeisler
Address 1055 W. Cold Spring Date signed 1/14/48
Zeisler x

VS 150

659060 659060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw Place & Brooks Lane. Esplanade Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 83 Years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME LILLIE G. FLEISCHMANN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Ernest Fleischmann.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1862.

8. AGE: Years 85 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Port Deposit, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Albert Gottschalk,
13. Birthplace Germany.

MOTHER
14. Maiden Name Rosa Ullman,
15. Birthplace Germany.

16 (a) Informant Mr. Albert Fleischmann,
(b) Address Pk. Heights & Slade Aves.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.16.48. (month) (day) (year)
(c) Cemetery or Crematory Oheb Shalom
Location Baltimore, Md.

18 (a) Funeral director Bride Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 (a) JAN 15 1948 (Date rec'd by registrar) (b) Lexington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15th. 1948 at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Jan 15 1948, and that I last saw him alive on Jan 14 1948.

Immediate cause of death: Myocardial failure — Duration: 1 year

Due to: Arteriosclerosis — 5 yrs

Due to:

Other Conditions: Cardiac Insufficiency — 5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. Frederick Lantz

Address Temple Garden Apts. Date signed 1/15/48 M. D.

659061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

659061
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 S. Clinton St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - -

3 (a) FULL NAME Clara O'Connor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Mar. 8, 1885

8. AGE: Years 62 | Months 10 | Days 6 | If less than one day ___ hr. ___ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name John O'Connor
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Cunningham
15. Birthplace Maryland

16 (a) Informant Frank O'Connor
(b) Address 924 S. Clinton St.

17 (a) Burial (b) Date thereof 1-17-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.

18 (a) Funeral director Libby & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) JAN 5 1948 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Jan. 1948, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to Jan 14 1948, and that I last saw h[illegible] alive on Jan 13 1948.

Immediate cause of death	Duration
Chronic Myocarditis	
Chronic Nephritis	
Due to Terminal Pneumonia	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. Joseph Tierney M.D.
Address 1441 Reisterstown Rd. Date signed 1/14/48

VS 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

659062 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Winston Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Catherine H Birmingham

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20. 1917

8. AGE: Years 30 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Catonsville Md (Town, county, and state)

10. Usual Occupation Typewriter

11. Industry or business Stanley Home Prod

FATHER 12. Name (Unknown) Hunter
13. Birthplace Md

MOTHER 14. Maiden Name Sally (Unknown)
15. Birthplace Md

16 (a) Informant Charles A Birmingham
(b) Address 1206 Winston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilhelm & Son Inc
(b) Address 2101 E Fort Ave

19 (a) JAN 5 1948 (Date received by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1948, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1948 to Jan 13 1948 and that I last saw her alive on Jan 12 1948

Immediate cause of death Pulmonary Edema and cardiac dilatation — Duration 5 days

Due to Post operative hemorrhage and shock

Due to

Other Conditions Renal insufficiency

(Include pregnancy within 3 months of death)

Date of operation Jan 10, 1948

Major findings of operation: Chronic pelvic inflammatory disease

of autopsy: Clinical Surgical Diagnosis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos L McCormack M. D.
Address U.S.P.H.S. Date signed 1-12-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 783a

Registered No. 659063

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County St. Geo's Co.
(c) City or town Brentwood (If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Valta ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard Moriarity

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex: Male | Color or race: White | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Ella Mae

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) 3-21-1900

8. AGE: Years 47 | Months -9 | Days 13 | If less than one day 24 hr. — min.

9. Birthplace Wash. D.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Moriarity
13. Birthplace Va.

MOTHER
14. Maiden Name Ida V. Thompson
15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Washington D.C.

18 (a) Funeral director W.H. Chambers.
(b) Address 617 1/2 8th S.E. Wash D.C.

19 (a) JAN 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14-1948, at 4:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9-1947 to 1-14-1948, and that I last saw h[illegible] alive on 1-14-1948

Immediate cause of death: Subarachnoid hemorrhage — Duration 12 hrs

Due to: Brain abscess — Duration 2 w

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Victor A. McKusick, M.D.
Address Johns Hopkins Hosp. Date signed 1/17/48

VS 150

G59064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G59064 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2930 Ba ker St.
(c) Hospital or institution: -- 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 Baker St. (If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME LOUISA M. KENNARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) jun. 16, 1869

8. AGE: Years	Months	Days	If less than one day
78	6	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation School Teacher (Retired)
11. Industry or business Baltimore, Md.

FATHER
12. Name Branson Forney kennard
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine C. Magruder
15 Birthplace Beltsville, Md.

16 (a) Informant Miss Grace Kennard
(b) Address 2930 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/48 (month) (day) (year)
(c) Cemetery or crematory XXXXX Woodlawn
Location Ba ltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC,
(b) Address North & Pa. Aves; Balto., Md.

19 (a) JAN 15 1948 (Date rec'd by registrar) (b) Luther T. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1948 19..., at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1948 to Jan 14 1948 and that I last saw her alive on Jan 13 1948

Immediate cause of death	Duration
Pulmonary Oedema.	7 days
Due to Cardio Vascular disease,	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.D.
Address 3200 Garrison Blvd Date signed 1/15/48

VS 150

G59065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

Registered No. G59065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21/2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 Milford Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME ANNIE E. WOMACK

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Benjamin F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 16, 1873

8. AGE: Years	Months	Days	If less than one day
74	9	27 28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name George W. Jaffers
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Pumphrey
15 Birthplace Virginia

16 (a) Informant Mr. John W. Womack
(b) Address 3804 Hadley Sq.

17 (a) Burial (b) Date thereof 1/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves., Balto. Md.

19 (a) JAN 15 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13, 1948 19 , at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Jan 13 1948 and that I last saw alive on 19

Immediate cause of death Pneumonia

	Duration
Due to	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Lunch M. D.
Address 4329 Lehigh Ave Date signed Jan 14

G59066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. G59066

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2909 Boarman Ave.
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) -- 15 → 19
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Boarman Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME WILLIAM HENRY KENNARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW 1	yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elsie W. Kennard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1894

8. AGE: Years	Months	Days	If less than one day
53	3	28	..hr. ..min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Assistant Chief
11. Industry or business Bethlehem Steel Ship Bldg

FATHER
12. Name George F. Kennard
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Munder
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elsie W. Kennard
(b) Address 2909 Boarman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/48 (month) (day) (year)
(c) Cemetery or crematory XXXXXX Woodlawn
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto., Md.

19 (a) JAN 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1948 19.. at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1948 to Jan 14 1948 and that I last saw him alive on Jan 14 1948

Immediate cause of death	Duration
Coronary Thrombosis	1/7/48
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John D Bubert M. D.
Address 1809 Park Heights Ave Date signed 1/14/48

VS 150

G59067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓97

Registered No. G59067

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2417 N. Pulaski St.
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 Pulaski St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country --

3 (a) FULL NAME HENRY CHARLES DECKMAN

3 (b) If veteran, name war ---
3 (c) Social Security Account No. Yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jul. 20, 1889

8. AGE: Years	Months	Days	If less than one day
58	5	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Western Md. R.R.
11. Industry or business --

FATHER
12. Name Henry Charles Deckman
13. Birthplace Germany

MOTHER
14. Maiden Name Meta Wittman
15 Birthplace Germany

16 (a) Informant Mrs. Frank Nichols
(b) Address 5508 Belleville Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/48 (month) (day) (year)
(c) Cemetery or crematory St. Pauls Cem. of Violetsville
Location Violetsville, Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto, Md.

19 JAN 15 1948 (b) (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13, 1948 19 , at 7:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10/45 1945 to 1/10 1948 and that I last saw h[illegible] alive on Jan 10 1948

Immediate cause of death	Duration
Cardiac Infarction Coronary	
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Walkenbree Ford
Address 20 S. Preston St. Date signed 1/14/48 M. D.

VS 150

X

G59068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G59068

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2926 Harford Rd.
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

9-6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Ba ltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2926 Harford Rd. (If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME SOPHIAL. GUYTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Elisha Guyton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1856

8. AGE: Years	Months	Days	If less than one day
92	0	5	..... hr. ..... min.

9. Birthplace Ba ltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business --

FATHER
12. Name David Reese
13. Birthplace Wales

MOTHER
14. Maiden Name Louise ?
15 Birthplace Wales

16 (a) Informant Mrs A.C. Dietrich
(b) Address 2926 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Johns Epis. Com.
Location (Waverly) Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto., Md.

19 (a) JAN 15 1948 (Date received by Registrar) (b) Tumerington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1948 19..., at 3:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1932 to Jan. 14 1948 and that I last saw h-- alive on Jan. 13 1948

Immediate cause of death	Duration
(a) Cardiac failure	2 Days
Due to (b) Arteriosclerosis	
Due to (c) Senility	10 yrs.
Other Conditions Senile dementia	10 Yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury?

23. Signature Edward Tiernan M. D.
Address 225 W. Fayette St. Date signed 1/14/48

G59069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59069

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W 40th Street
(c) Hospital or institution:
Home for Incurables 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs, 4 mos. 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 years, 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Fort

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1866

8. AGE: Years	Months	Days	If less than one day
81	11	15	hr. min.

9. Birthplace Ellicott City Md.
(Town, county, and state)
10. Usual Occupation Clerk - Retired
11. Industry or business Grocery-Feed

FATHER
12. Name Bernard Fort
13. Birthplace England

MOTHER
14. Maiden Name Eliza S. Hagan
15. Birthplace Savage, Md.

16 (a) Informant (Mrs.) Frances M. Hazard (Supervisor)
(b) Address Home for Incurables

17 (a) Burial (b) Date thereof 1/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ St. Johns
Location Ellicott City, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) JAN 15 1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1948, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 4, 1944 to Jan. 14, 1948, and that I last saw him alive on Jan. 13, 1948.

Immediate cause of death Congestive Heart Failure — Duration 2 months
Due to Arteriosclerotic Cardiac Vascular Disease — 10 years?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Conner M.D.
Address 11 E. Chase St. Date signed 1/19/48
Baltimore 2, Md.

659070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

659070 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25-
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2340 Annapolis Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID Lee SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No. 22.216-01-6649

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence A Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18-1911

8. AGE: Years	Months	Days	If less than one day
36		27	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Fire Salesman.
11. Industry or business

FATHER
12. Name Frank F. Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma E. Rush
15. Birthplace Balto Md.

16 (a) Informant Mrs. Florence A. Smith
(b) Address 2340 annapolis Rd.

17 (a) Burial (b) Date thereof Jan-19-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Balto. Md.

18 (a) Funeral director Francis Cook & Son
(b) Address 1600 W North ave

19 (a) Jan 15 1948 (b) Lauriston Williams M.D.
(Date received by Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1948, at 1 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 1-14-48

65071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 65071

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 Penrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Henderson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 24 Feb 1866

8. AGE: Years	Months	Days	If less than one day
81 82	11 10	18	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER: 12. Name John Henderson
13. Birthplace Md.

MOTHER: 14. Maiden Name Georgianna Russell
15. Birthplace Md.

16 (a) Informant E. Henderson
(b) Address 1900 Penrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Rd.

18 (a) Funeral director Harry A Wikta
(b) Address 4101 Edmondson Ave

19 (a) JAN 15 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Jan 1948, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Dec. 1947 to 14 Jan 1948, and that I last saw him alive on 13 Jan 1948.

Immediate cause of death	Duration
Thrombosis	
Due to R. bronchopneumonia	
Due to R. pneumonia (Chron lobe.) & pleural effusion	
Other Conditions Multiple avitaminosis	

(Include pregnancy within 3 months of death)
Date of operation Thoracentesis 19 Dec.
Major findings of operation: Effusion of pus.
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature V. A. Cacace, M. D.
Address Franklin Square Hospital Date signed 14 Jan 48

659072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 R

Registered No. 659072

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3809 Edmondson Ave.
(c) Hospital or institution: 2D
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Edmondson ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Edward Tubman

3 (b) If veteran, name war: 1st world war
3 (c) Social Security Account No. 08646-5889

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Estelle Tubman
6 (c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) June 17-1876
8. AGE: Years 71 | Months 6 | Days 27+2 | If less than one day hr. min.
9. Birthplace Edmondstown Ind. (Town, county, and state)
10. Usual Occupation Retired Marine engineer
11. Industry or business

FATHER
12. Name Samuel R. Tubman.
13. Birthplace St Marys Co. Md.

MOTHER
14. Maiden Name Mary Beaman
15. Birthplace St Marys Co. Md.

16 (a) Informant Estelle Tubman
(b) Address 3809 Edmondson ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore Memorial
Location Loyola Rd.

18 (a) Funeral director Harry A. Wright
(b) Address 4101 Edmondson Ave

19 (a) JAN 15 1948 (Date rec'd by registrar) Clayton Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 - 1948, at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 - 1942 to January 13 1948, and that I last saw h[illegible] alive on 1-11 - 1948.

Immediate cause of death	Duration
Angina Pectoris	6 yr
Due to —	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Riland M. D.
Address 2532 Edmondson Ave Date signed 1-13-48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G59073

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1453 Andrae Street (or location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Rasmussen

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	MARRIED

6 (b) Name of husband or wife ANTON M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 24, 1876

8. AGE: Years	Months	Days	If less than one day
71	5	21	22 hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business OWN HOME

FATHER
12. Name ALBERT SOMMER
13. Birthplace GERMANY

MOTHER
14. Maiden Name WILHELMINA FERBER
15. Birthplace GERMANY

16 (a) Informant ANTON M. RASMUSSEN
(b) Address 1453 ANDRAE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 17 1948 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location PARKVILLE, Md.

18 (a) Funeral director WILLIAM COOK, FUN.
(b) Address 1217 ST. PAUL ST.

19 (a) JAN 15 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 3 D

20. DATE OF DEATH January 15, 1948, at 1 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull & Intra cranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-14-48 at ? 6 P. M. 24/1
(b) Where did injury occur? 1453 Andrae St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NO
(d) Means of injury Fell down flight of stairs

23. Signature [signature] M.D. Medical Examiner.
Date signed 15 Jan 48

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 659074 OVER 1176

659074

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3013 Erdman Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Erdman Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Seth W. Barton

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-01-3556

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Grace L. Barton

6 (c) If alive, give age: ~~70~~ 71

7. Birth date of deceased (mo., day, yr.) March ~~21, 1883~~ 21, 1877

8. AGE: Years ~~64~~ 68 | Months 9 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business Vienna Restaurant

FATHER 12. Name Seth Barton

13. Birthplace Baltimore

MOTHER 14. Maiden Name Barbara Whittle

15. Birthplace Harford, County

16 (a) Informant S. LeRoy Barton

(b) Address 3013 Erdman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1948 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Baltimore County

18 (a) Funeral director Frederick A. Cole

(b) Address 1200 W. Lombard St.

19 (a) JAN 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1948, at 9:23 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1947 to January 13 1948, and that I last saw h[illegible] alive on January 13 1948

Immediate cause of death: (a) Coronary Occlusion — Duration 3 —
Coronary Thrombosis — 18 —
due to Generalized Arteriosclerosis — 10 —
Due to
Other conditions: Chronic Interstitial Nephritis — 9 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Tom Primakoff, M.D.
Address 1 W. Mt. Vernon Pl. Date signed 1/15/48

Primakoff 94a

G59075 Ast-H

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G59075 Registered No. 191617

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Elbert St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Freda Frederick

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-14-02

8. AGE: Years	Months	Days	If less than one day
45	1	1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Frederick Sr.
13. Birthplace Md

MOTHER
14. Maiden Name Louise Hurtz
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-48 (month) (day), (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schnauf
(b) Address 210 Frederick Ave.

19 (a) [illegible] 1948 [illegible] Wilkinson

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 1948, at 3:14 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1947 to 1-15 1948 and that I last saw her alive on 1-15 1948.

Immediate cause of death	Duration
Acute glomerulo-nephritis	1 mo
Due to	
Due to	
Other Conditions Pyelonephritis, rapid-coma (Include pregnancy within 3 months of death)	30 yr.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Lisson M. D.
Address Johns Hopkins Hosp. Date signed 1-19-48

VS 130

659076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 659076

GH. 116479

157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Never

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Churchton MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Churchton MD.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janice Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19 -1947

8. AGE: Years	Months	Days	If less than one day
	11	26	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elmer Thompson
13. Birthplace MD.

MOTHER
14. Maiden Name Esther Scott
15. Birthplace W.VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan 17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Churchton Md

18 (a) Funeral director J. B. Johnson
(b) Address Baltimore Md

JAN 15 1948 (b)
(Date rec'd by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 14 - 1948 8.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 10 - 1948 to 1 - 14 - 1948, and that I last saw her alive on 1 - 14 - 1948

Immediate cause of death	Duration
Cerebral Anoxemia	3 days
Due to Congenital Heart Disease (Situs inversus)	1 hour.
Due to	
Other Conditions Cyanosis	11 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Boyer M. D.
Address Balt. City Hosp. Date signed 15 Jan 48

G55077 G55077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 760 Grantley street
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 760 Grantley st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Jory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Clara B. Jory (nee Phillippe)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1863

8. AGE: Years 84 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Rebecca M. Hoenes
(b) Address 760 Grantley street (daughter)

17 (a) Burial (Burial, cremation, or removal) (b) Date of [illegible] Jan. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Western Cemetary
Location Baltimore, Md.

18 (a) Funeral director [illegible] A. Boisord Evans
(b) Address 1400 S. Charles st. Balto. Md.

19 (a) Jan 15 1948 (b) [illegible] Date received by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1948 at 7.45A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1947, to Jan. 13, 1948, and that I last saw him alive on Jan. 13, 1948

Immediate cause of death	Duration
Cardiac Failure	2 wks.
Due to Generalized arterial-sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benger A Kemp M. D.

Address 3030 Edmondson Ave. Date signed 1/14/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

65078 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2410 Chelsea Terrace
(c) Hospital or institution: 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2410 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Belle Ritter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 29, 1864

8. AGE: Years	Months	Days	If less than one day
83	4	15 16	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Schoen-Russell, Inc.

FATHER
12. Name Emanuel J. Ritter
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Elizabeth Keller
15. Birthplace Baltimore County, Md.

16 (a) Informant Mrs. Alma Orwig
(b) Address 2410 Chelsea Terrace

17 (a) Burial (b) Date thereof Jan. 16, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Baltimore, Md.

18 (a) Funeral director Phillips Funeral
(b) Address 4510 Liberty Heights Ave.

19 (a) 1948 Huntington Williams M.D.
(Date received by registrar) Registrar

JAN 17 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1948, at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Jan 14 1948 and that I last saw her alive on Jan 13 1948

Immediate cause of death: Arteriosclerotic Cardio-Vascular Renal Disease

Duration
?

Due to: (old age)

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. M. J. Blum M. D.
Address 1206 E. Preston St. Date signed

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

65079 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 E. 25th St.
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 E. 25th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ~~Charles H. MacPherson~~ Charles H. MacPherson (McPherson)

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pearl E. MacPherson

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) January 31, 1884

8. AGE: Years 65 | Months 11 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace: Nova Scotia (Town, county, and state)

10. Usual Occupation: Retired Illustrator & Artists

11. Industry or business:

FATHER
12. Name: Mr. MacPherson
13. Birthplace: Scotland

MOTHER
14. Maiden Name: Mary MacGowen
15. Birthplace: Nova Scotia

16 (a) Informant: Mrs. Pearl E. MacPherson
(b) Address: 400 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Nat'l Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Miller & Amoroso
(b) Address: 4510 Liberty Heights Ave.

19 (a) ____ (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN

Vs 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Jan. 1948, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Wm. H. Barnum, Jr. M.D. Medical Examiner.
Date signed 15 Jan. 1948

T

410 G59080 BALTIMORE CITY HEALTH DEPARTMENT X 128 G5[illegible]
CERTIFICATE OF DEATH No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument St.
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Georgia (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolphus Calloway JR

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-45

8. AGE: Years	Months	Days	If less than one day
3 yrs 2	0	14	hr. min.

9. Birthplace Georgia. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Adolphus Calloway
13. Birthplace Ga.

MOTHER
14. Maiden Name Helen Greaves
15. Birthplace Ga.

16 (a) Informant JOHNS HOPKINS HOSPITAL Records
(b) Address

17 (a) Removal (b) Date thereof 1-16-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory —
Location Washington Ga.

18 (a) Funeral director Geo L. Beyer Jr
(b) Address 1512 Hollins St

19 (a) 1-15-1948 (b)
(Date rec'd by Registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1948 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1947 to Jan. 15 1948 and that I last saw him alive on Jan 15 1948

Immediate cause of death	Duration
Pulmonary congestion	
Due to pancreatic cystic fibrosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E Morris Jr.
Address Johns Hopkins Hosp Date signed 15 Jan 48

X

G59081 BALTIMORE CITY HEALTH DEPARTMENT G59081
CERTIFICATE OF DEATH 157E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County McCoole
(c) City or town Keyser
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21st Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald McCoole Jr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-47

8. AGE: Years | Months: 5 | Days: 13 | If less than one day: hr. min.

9. Birthplace W. Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Donald McCoole
13. Birthplace W. Va.

MOTHER
14. Maiden Name Marguerite Wilbis
15. Birthplace W. Va

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan. 16 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Keyser W. Va

18 (a) Funeral director Henry H. Perkins & Sons
(b) Address McCulloch & Cockrell Sts

19 (a) JAN 15 1948 (Date rec'd by Registrar) (b) Arlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1948, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12-1948 to 1-15-1948 and that I last saw him alive on 1-15-1948.

Immediate cause of death Cardio-respiratory failure — Duration minutes

Due to Congenital heart disease Transposition of Great Vessels — Duration 5 mos.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 1-15-48

Major findings of operation: Congenital heart disease

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Caylor, Jr. M. D.
Address The Johns Hopkins Hospital Date signed 1-15-48

VS 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59082 G59082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James M. Coulter

3 (b) If veteran, name war: SAW
3 (c) Social Security Account No. 213-14-9818

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1870

8. AGE: Years 77 | Months 4 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Coulter
13. Birthplace Md.

MOTHER
14. Maiden Name Johanna Douglas
15. Birthplace Ga.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto National
Location Balto., Md

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) JAN 15 1948 (Date rec'd by registrar) (b) Signature Huntington Williams, jr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1948, at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1947 to Jan. 15 1948, and that I last saw him alive on Jan. 15 1948

	Duration
Immediate cause of death: Cerebral hemorrhage, right	17 days
Due to	
Due to	
Other Conditions: Generalized arteriosclerosis (Include pregnancy within 3 months of death)	UNKNOWN

Date of operation
Major findings of operation:
of autopsy: none done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 1/15/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~59083~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 59083

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General. 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 Hillman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY A. WELSH

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Jerome Welsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21 1872

8. AGE: Years 65 | Months 3 | Days 24 | If less than one day: hr. min. 1882

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Lenard Richards
13. Birthplace md.

MOTHER — 14. Maiden Name Frances E Dixon
15. Birthplace md

16 (a) Informant Mrs Frances Moore
(b) Address 3501 13th st n W Washington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Washington D.C.

18 (a) Funeral director Wm Zumbrun Son
(b) Address North & Penn Ave.

19 (a) JAN 16 1948 (Date rec'd by registrar) (b) Courtney Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15, 1948, at 3:28 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Jan 15 1948, and that I last saw h[illegible] alive on Jan 15, 1948.

Immediate cause of death — Medical Service

	Duration
Due to Coronary Thrombosis	
Due to ASCVD	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: ASCVD Coronary Dis

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address W. B. G. H. Date signed 1/18/48

VS 150

G59084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G59087 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 N. Monroe St. / 4
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME LAWRENCE SCHARNAGLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	Yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Carrie Scharnagle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1881

8. AGE: Years	Months	Days	If less than one day
66	3	4	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Barber
11. Industry or business --

FATHER
12. Name Lawrence Scharnagle
13. Birthplace Germany

MOTHER
14. Maiden Name Elizebeth Hesse
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Carrie Scharnagle
(b) Address 1918 N. Monroe St.

17 (a) Burial (b) Date thereof 1/17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) JAN 16 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1948 19 , at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1947 to Jan 14 1948, and that I last saw h-- alive on Jan 14 1948

Immediate cause of death	Duration
Coronary Thrombosis	1/14/48
Due to Chr. Myocarditis	1945
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Brown M. D.
Address 1663 W. Lost St. Date signed 1/15/48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 97839 159

Registered No. C 69035

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2966 Cornwall Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Williams (130498)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	0	0	1 hr. 0 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Earl Williams
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Helen Harris
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 3, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 16 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1947, at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30, 1947, to Dec. 30 1947, and that I last saw her alive on Dec. 30, 1947

Immediate cause of death	Duration
Prematurity	
Congenital anomalies	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B C Williams M. D.
Address The Johns Hopkins Hospital Date signed 12-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 659086

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ... 57
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ...
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Lanvale St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ...

3 (a) FULL NAME Charles Bilas

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Black	married

6 (b) Name of husband or wife ?
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1896

8. AGE: Years	Months	Days	If less than one day
51	1	12	... hr. ... min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation ...
11. Industry or business ...

FATHER
12. Name Henri Bilas
13. Birthplace South Carolina

MOTHER
14. Maiden Name Sarah Pompey
15. Birthplace South Carolina

16 (a) Informant ...
(b) Address ...

17 (a) ... (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)
(c) Cemetery or crematory ...
Location Johns Hopkins Medical School JAN 3, 1948

18 (a) Funeral director Commissioner of Health
(b) Address ...

19 (a) JAN 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1947 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1947 to Dec 29 1947, and that I last saw h.l. alive on Dec 29 1947.

Immediate cause of death	Duration
Ca. of Stomach	
Due to	
Due to	
Other Conditions Gastric Ulcer	

(Include pregnancy within 3 months of death)

Date of operation ...
Major findings of operations: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ...
(e) Means of injury ...

23. Signature Frank A. Lorraine
Address Mercy Hosp Date signed 1/1/49

(1) 037 ✓ 46B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Morris Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brown, William

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Betty Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1898

8. AGE: Years	Months	Days	If less than one day
59	5	25	hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Locat Johns Hopkins Medical School JAN 13 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 16 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1 1948, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1947 to Jan 1 1948 and that I last saw he alive on Jan 1 1948

Immediate cause of death Pyloric Obstruction — Duration

Due to Probable Carcinoma of stomach

Due to

Other Conditions Intestinal Adhesions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marcus W. Moore Sr. M. D.
Address Provident Hospital Date signed 1/8/48

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659088 Bc # 48-01580

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 659088

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Doctors Hospital 63
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 N. Maderia
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Hershey (Hursey)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/5/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur Mack Hershey
13. Birthplace South Carolina

MOTHER
14. Maiden Name Maybelle Irene Strickland
15 Birthplace Portsmouth, Va.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 12, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5, 1948 at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1948 to Jan 5 1948 and that I last saw h alive on Jan 5 1948

Immediate cause of death: Prematurity — Duration

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Olsan M. D.
Address 876 Wilkens Ave Date signed 1/9/48

C59039 C97852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

C59039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital 133
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 13 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Woodbrook Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Walker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Newborn

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-47

8. AGE: Years	Months	Days	If less than one day
			13 hr. 33 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER 12. Name Nathaniel Obie Walker
13. Birthplace ? South Carolina

MOTHER 14. Maiden Name Delores Sylvia Keat
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Delores Walker
(b) Address 2618 Woodbrook Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 8, 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) JAN 16 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1947, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26 1947, to 12-27 1947, and that I last saw her alive on 12-27 1947

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H R S Butler
Address Lying-In Hosp Date signed 1/8/48

VS 150

Dr Ott
Dr. 48 Path. Autopsy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. C59090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL State Anatomical 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) Hrs 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Homewood ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby "B" Day Thompson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-48

8. AGE: Years | Months | Days | If less than one day: 15 hr. min.

9. Birthplace J. H. H. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lillian Thompson

13. Birthplace

MOTHER 14. Maiden Name Lillian Thompson

15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL Records

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 8, 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 16 1948 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1948, at 2.30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1948 to 1-7 1948 and that I last saw him alive on 1-7 1948

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry M. Seidel

Address Johns Hopkins Hospital Date signed 1/7/48 M D

VS 150

X

659091 B.C # 48-015179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 659091

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL (3)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 N. Madeira St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Boy Hursey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-5-48

8. AGE: Years | Months | Days | If less than one day: 6 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Arthur Hursey

13. Birthplace ?

MOTHER 14. Maiden Name Mabel Irene Strickland

15. Birthplace ?

16 (a) Informant Records JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School JAN 7, 1948
Location

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5, 1948, at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1948 to Jan 5 1948; and that I last saw him alive on Jan 5 1948.

Immediate cause of death prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Julian Chisolm Jr.

Address Johns Hopkins Hosp. Date signed 1-5-48

VS 110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

GM. 116224 — 126 — Registered No. 032

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals — 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55Minuets
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Cheapside (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oscar Hester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Catherine Hester

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29- 1889

8. AGE: Years	Months	Days	If less than one day
58yrs	6	2	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Hester (D
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Parrish (D
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School JAN 9, 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 - 1947, at 2.10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 - 1947 to Dec. 31- 1947, and that I last saw h Im alive on Dec 31 - 1947.

Immediate cause of death	Duration
Pulmonary tuberculosis probable	9
Due to	
Due to	
Other Conditions Malnutrition, Dehydration (Include pregnancy within 3 months of death)	5

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Balt. City Hosp. Date signed 1-8-48

V S 150

65093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 65093

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2227 Brookfield Ave
(c) Hospital or institution: 13-2

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 Brookfield Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Esther Dax

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Benjamin

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 83 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Sidney
13. Birthplace Russia

MOTHER 14. Maiden Name Pearl
15. Birthplace Russia

16 (a) Informant Mrs Sarah Weintraub
(b) Address 2227 Brookfield ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-48 (month) (day) (year)

(c) Cemetery or crematory Adas Israel
Location No Point German Hill Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 216 Eutaw Place

19 (a) JAN 16 1948 (Date rec'd by registrar) (b) ..... Registrar

V S 190

MEDICAL CERTIFICATION 48

20. DATE OF DEATH 1-15-1948 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1948 to Jan 14 1948 and that I last saw ... alive on 1-14 1948

Immediate cause of death: Coronary Occlusion — Duration .....

Due to ..... — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature H. H. Goldberg M. D.
Address 2225 Brookfield Ave Date signed 1-15-48

58094

GM. 116436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136a

Registered No. 58094

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 4-2
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Vaughn

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-3073

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Divorced

6 (b) Name of husband or wife Carrie Wms. Vaughn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
53 ?/			hr. min.

9. Birthplace VA. (Town, county, and state)
10. Usual Occupation Construction
11. Industry or business Belle Grove Corp.

FATHER
12. Name ? Nathan Vaughn
13. Birthplace ? Va

MOTHER
14. Maiden Name ? Garrett
15. Birthplace ? Va

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave

19 (a) JAN 16 1948 (Date received by registrar) (b) Wallace J. Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14- 1948, at 11.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8-48 1948 to 1-14-1948, and that I last saw him alive on Jan. 14 - 1948

Immediate cause of death	Duration
Urinary extravasation	1 week
Due to Urethral stricture infested.	Unknown
Due to	
Other Conditions Aspiration following vomiting. Pulmonary Congestion (Include pregnancy within 3 months of death)	
Date of operation 1-9-48	
Major findings of operation: Urinary extravasation	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy M.D. M. D.
Address Baltimore City Hospitals Date signed 1-14-48

59095 697712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G59095 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University of Maryland Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 East Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Sabo

3 (b) If veteran, name war:

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 26 Dec, 1947

8. AGE: Years | Months | Days | If less than one day: 4 hr. 25 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant (newborn)

11. Industry or business

FATHER
12. Name Joseph Sabo
13. Birthplace Pennsylvania.

MOTHER
14. Maiden Name Eleanor Matenkoski
15. Birthplace Pittsburg, Pa.

16 (a) Informant Mother
(b) Address 110 East Preston Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 5, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 16 1948 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Dec, 1947, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Dec 1947 to 26 Dec 1947, and that I last saw her alive on 26 Dec 1947

Immediate cause of death	Duration
Fatal atelectasis - Marasmus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. L. Casey Jr. M. D.
Address University Hospital Date signed 12-30-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59096

B. C. - 48-00081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G59096 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Green Sts
(c) Hospital or institution: University Hospital 22nd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 660 Haw Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Brenda Paulette Nicholson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1948

8. AGE: Years | Months | Days | If less than one day: 8 hr. 57 min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Taylor
13. Birthplace Columbia S.C.

MOTHER
14. Maiden Name Helen Nicholson
15. Birthplace Balto Md.

16 (a) Informant Helen Nicholson
(b) Address mother

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 5, 1948

18 (a) Funeral director Commissioner of Health
Address JAN 16 1948

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1948, at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Jan 1 1948, and that I last saw her alive on Jan 1 1948

Immediate cause of death: Cardio-respiratory failure — Duration

Due to: Prematurity

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos Shear, M.D.
Address University Hospital Date signed 1/1/48

G55037

AC. 48-10384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G55037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 27-7
(b) Street address Fayette and Calhoun Sts.
(c) Hospital or institution:
FRANKLIN Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Fleetwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl KEENE.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 11, 1948

8. AGE: Years	Months	Days	If less than one day
			7 hr. min.

9. Birthplace BALTIMORE, Md.
(Town, county, and state)

10. Usual Occupation –

11. Industry or business –

FATHER
12. Name HARDING THEODORE KEENE
13. Birthplace ESSEX, Md.

MOTHER
14. Maiden Name LORETTA MARIE GOBRECHT
15. Birthplace BALTIMORE, Md.

16 (a) Informant LORETTA KEENE
(b) Address 2906 FLEETWOOD AVE

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 13, 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 16 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 11 1948, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1948 to 1/11 1948 and that I last saw her alive on 1/11/1948

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D.P. Cruikshank
Address Franklin Square Hosp. Date signed 1/12/48

G59038 ✓ X G59038

BC48-00385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts.
(c) Hospital or institution:
Franklin Square Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex 21
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Marlyn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Maldeis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1948

8. AGE: Years	Months	Days	If less than one day
			8 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Edward Wilson Maldeis
13. Birthplace Balto., Co., Md.

MOTHER
14. Maiden Name Ella May Schafer.
15. Birthplace Balto., Md.

16 (a) Informant Ella Maldeis
(b) Address 423 N. Marlyn Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 13 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) JAN 16 1948 (Date rec'd by registrar) (b) Washington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan, 11 1948 at 6:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1948, to 1/11 1948, and that I last saw him alive on 1/11/1948

Immediate cause of death Cardio — Respiratory Failure

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O.P. Brinkenhank
Address Franklin Square Hosp. Date signed 1/16/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

659099

BALTIMORE CITY HEALTH DEPARTMENT

B.C. 48-00458 CERTIFICATE OF DEATH 159

659099
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Streets
(c) Hospital or institution: University Maryland Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1052 Pennsylvania Avenue
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Gaines

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Premature

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-48

8. AGE: Years	Months	Days	If less than one day
			0 hr. 5 min.

9. Birthplace University Hospital (Town, county, and state)
10. Usual Occupation Premature
11. Industry or business

FATHER
12. Name Wilbur Taylor
13. Birthplace Unknown.

MOTHER
14. Maiden Name Irene GAINES
15. Birthplace Maryland.

16 (a) Informant Mother
(b) Address 1052 Pennsylvania Ave. Balt. Md.

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
Cemetery or crematory
Location University Medical School JAN 9, 1948
Commissioner of Health

18 (a) Funeral director
(b) Address
JAN 16 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1948 at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1948 to 1-6 1948 and that I last saw h[illegible] alive on 1-6 1948

Immediate cause of death Erythroblastosis Fetalis — Duration

Due to

Due to

Other Conditions Prematurity; Fetal Atelectasis; Hydrops Fetalis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. L. Lowry, Jr. M. D.
Address University Md. Hospital Date signed 1-6-48
Baltimore, Md. X

G59100

BALTIMORE CITY HEALTH DEPARTMENT

BC: C 97755 CERTIFICATE OF DEATH 161a

G59100
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St
(c) Hospital or institution: University of Maryland Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 31 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Saharol St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Meekins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (d) Single, married, widowed, or divorced.
F	Neg	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1947

8. AGE: Years	Months	Days	If less than one day
			31 hr. min.

9. Birthplace Baltimore, Baltimore Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert Meekins
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 5, 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) JAN 16 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1947, at 6:00 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1947, to Dec 29 1947, and that I last saw h alive on Dec. 29 1947.

Immediate cause of death	Duration
Cardiac Resp failure	
due to acute infection	
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Hunterdon C. Hoyle M. D.
Address University Hosp. Date signed 12/29/47

X

G59101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G59101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Poppleton + Lombard
(c) Hospital or institution West Balto. Gen. Hosp. 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 N. Chapel St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David J. Engleman.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-3821

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Annie Engleman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-12-[illegible] 1896

8. AGE: Years	Months	Days	If less than one day
51	7	1	hr. min.

9. Birthplace Westminster, Md.
(Town, county, and state)
10. Usual Occupation Assistant Retiner
11. Industry or business

FATHER
12. Name Josiah
13. Birthplace Western Md

MOTHER
14. Maiden Name Sarah Mickey
15. Birthplace Western Md.

16 (a) Informant Anna E. Engleman
(b) Address R # 13 - Box 34 A. Cedar Heights Md

17 (a) Burial (b) Date thereof 1/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North gate + Rose St

18 (a) Funeral director Devine + Hoffman
(b) Address 1639 Broadway

19 (a) JAN 16 1948 (Date rec'd by Registrar) (b) Dorothy Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13- 1948, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1947, to 1-13 1948, and that I last saw h[illegible] alive on 1-18- 1948

Immediate cause of death Ruptured pertoneal ulcer + asphyxia

Due to Carcinoma transverse colon

Due to Operation for Carcinoma of stomach

Other Conditions Coronary thrombosis

(Include pregnancy within 3 months of death)

Date of operation 11-22-47

Major findings of operation: Carcinoma of stomach + metastasis.

of autopsy: Ruptured ulcer + asphyxia

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. W. Bridenbaugh M.D.
M. D.
Address W. Balto. Gen. Hosp. Date signed Jan 14 48

65302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 65302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 W. Ostend St.
(c) Hospital or institution: 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 W. Ostend St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna Washington.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation Domestic.

11. Industry or business

FATHER
12. Name John Gray
13. Birthplace Va.

MOTHER
14. Maiden Name Frances Woods.
15. Birthplace Washington D.C.

16 (a) Informant Frances Ferguson
(b) Address 816 W. Ostend St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 1-17-48

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1005 N. Broadway

19 (a) JAN 16 1948 Registered by (signature) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1948, at 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1947 to Jan 14 1948 and that I last saw her alive on Jan 13 1948.

Immediate cause of death: Carcinoma of Uterus.

Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert L. Moseley, M.D.

Address 2024 Madison Ave Date signed 1/14/48

Herbert L. Moseley M.D.

VS 150

659103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 659103

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4813 Belair Rd
(c) Hospital or institution: 26-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4813 Belair Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Zanelotti

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.: No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Lucy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 1870

8. AGE: Years 75 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Charles Zanelotti
13. Birthplace Italy

MOTHER
14. Maiden Name Margaret
15. Birthplace Italy

16 (a) Informant Rose Hunekie
(b) Address 4804 Althea Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1 17 48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR RD

18 (a) Funeral director DIPPEL BROS.
(b) Address 1800 E. LOMBARD St

19 JAN 16 1948 (Date rec'd by registrar) (b) Huntington Williamson

MEDICAL CERTIFICATION

15

20. DATE OF DEATH Jan 13 1948 at 4: P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1947 to JAN 13 1948 and that I last saw h/im alive on DEC 13 1948

Immediate cause of death CEREBRAL HEMORRHAGH — Duration 5 WEEKS.
Due to HYPERTENSION
Due to
Other Conditions PLEURISY — 1 WEEK
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward J. Kavanagh M.D.
Address 3914 W. Belvedere Ave Date signed 1-14-48

V S 130

659104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered 659104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Lutheran and Comm.
(b) Street address 907 E. Preston St.
(c) Hospital or institution:
University Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys Farley 227-10-1249

3 (b) If veteran, name war

3 (c) Social Security Account No. 227-10-1249

4. Sex Female

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 34 | Months | Days | If less than one day hr. min.

9. Birthplace Petersburg Dec Va
(Town, county, and state)

10. Usual Occupation Telephone operator

11. Industry or business Civil Service

FATHER
12. Name Andrew J. Farley
13. Birthplace Petersburg Va

MOTHER
14. Maiden Name Margaret Lucas
15. Birthplace Petersburg Va

16 (a) Informant Mrs Ray Farley
(b) Address 212 Homewood Ave

17 (a) Burial (b) Date thereof Jan 17-1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Road

18 (a) Funeral director Joseph Farace Inc
(b) Address 2013 Greenmount Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 16 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14/48 19 , at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8-48 19 to 1/14/48 19 , and that I last saw h-- alive on 1/13/48 19 .

Immediate cause of death Respiratory failure — Duration

Due to failure of respiration Center in the medulla

Due to Sub-Arachnoid hemorrhage from Aneurysm

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Sub Arach hem of AV Aneu

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Farace Jr

Address Univ. Hosp Date signed 1/14/48

X

G59105 Schedel

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 170c

G59105 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1747 E. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Schedel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary L. Schedel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20-1879

8. AGE: Years 68 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired Lawyer

11. Industry or business

FATHER
12. Name John Schedel
13. Birthplace Germany

MOTHER
14. Maiden Name Swissler
15. Birthplace

16 (a) Informant Mary L. Schedel
(b) Address 1747 Lanvale St.

17 (a) Burial (b) Date thereof Jan. 17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John J. Miller
(b) Address 2334 Jefferson St.

19 (a) JAN 16 1948 (b) Huntington, Williams, M.D.
(Date filed by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1948, at 8 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull & Subdural Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-14-48 at 6 P. M. 7/4
(b) Where did injury occur? Bond & Gay Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Carl L. Pyle M.D.
Medical Examiner.
Date signed 15 Jan 48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/13

Registered No. 659106

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2432 E. Lafayette Ave.
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2432 E. Lafayette Ave.,
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Frances Nebohy-Nelby

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-6833

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1907

8. AGE: Years	Months	Days	If less than one day
40	10	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Nebohy
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Frances Joska
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Mildred Panuska - dght.
(b) Address 2432 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Oak Hill
Location Horner's Lane, Balto. Md.

18 (a) Funeral director C. E. Schimunek
(b) Address 2601-3-5 E. Madison Street

19 (a) 1-6-1948 (Date rec'd by registrar) (b) Huntington Williams Md. Registrar

JAN

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13 1948 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1948, to 1-13 1948, and that I last saw h[illegible] alive on 1-13 1948

Immediate cause of death Cardiac-resp insufficiency failure

Due to Pulm. tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Owen M. D.
Address 242 S Highland Ave Date signed 1-14-48

X

659107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

659107
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 935 N. Luzerne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Joseph MAYER

3 (b) If veteran, name war

3 (c) Social Security Account No. 150-01-5881

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary Drift Mayer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1895

8. AGE: Years 52 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Carl Mayer
13. Birthplace Germany

MOTHER
14. Maiden Name Theodora Ruf
15. Birthplace Germany

16 (a) Informant Mrs. Mary Drift Mayer
(b) Address 935 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 3-5 E. Madison Street

19 (a) JAN 16 1948 (Date rec'd by registrar) (b) Waiting for Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1948, at 9 15 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull.
Intracranial hemorrhage.
Contusion of brain.
Bronchopneumonia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-6-48 at 3 30 26/6 Lond. Cork & Leith Co.
(b) Where did injury occur? Pennsylvania R.R. & Old Annapolis Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from ladder

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed 1/15/48

VS 181

G59108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G59108 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Druid Hill (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Sanders (SANDERS)

3 (b) If veteran, name war

3 (c) Social Security Account No. 238-16-F093

4. Sex M | 5. Color or race N | 6 (a) Single, married, widowed, or divorced. Sing.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/21/04

8. AGE: Years 43 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Bishopville, S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Rose Sanders
13. Birthplace Bishopville, S.C.

MOTHER
14. Maiden Name Matilda Mae Manton
15. Birthplace Bishopville, S.C.

16 (a) Informant Mrs. Bertha Smyth
(b) Address 833 Druid Hill Ave.

17 (a) Burial (b) Date thereof 1-19-1948 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Md. Location Baltimore Co. Md.

18 (a) Funeral director Wm. Geo. H. Stallard
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Thomas Wellington M.D. (Date received by Registrar) Registrar

JAN 19 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1948 at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1948 to 1/14 1948 and that I last saw h alive on 1/14 1948

Immediate cause of death Subarachnoid Hemorrhage | Duration 2

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Preston Grant M.D.
Address 1514 Division Date signed 1/15/48

Not M.E.C. X

659109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH /47a

659109 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2120 Bank St
(c) Hospital or institution: 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Bank St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Waszkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife. Marcella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name John Waszkowski
13. Birthplace Poland

MOTHER 14. Maiden Name
15. Birthplace Poland

16 (a) Informant Marcella Waszkowski
(b) Address 2120 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) JAN 16 1948 (Filed by registrar) (b) Huntington Hillsboro M.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1948 at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Jan 15 1948 and that I last saw alive on Jan 15 1948

Immediate cause of death: CARCINOMA OF PHARYNX — Duration 12/25/47

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Ortega
Address 209 W Chester St Date signed 1/16/48

V S 150

059110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 059110

CM. 115283

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 N. Durham ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ivy Bethea

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23 - 1918

8. AGE: Years	Months	Days	If less than one day
29	1	22	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Bethea
13. Birthplace S.C.

MOTHER
14. Maiden Name Ada Sapp
15. Birthplace GA.

16 (a) Informant: Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day), (year)
(c) Cemetery or crematory Druid Hill Park
Location

18 (a) Funeral director Mrs. Cliff A. Elliott & Son
(b) Address 1129 N. Carrollton Ave.

19 (a) (Date received by local registrar) (b) Irvington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15-48 1948, at 10.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17-1947, to 1-15-1948, and that I last saw him alive on 1-15-1948.

Immediate cause of death	Duration
Pulmonary Tuberculosis	May 47
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Lebenson M. D.
Address Balto City Hosp. Date signed 1/15/48

G59111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G59111

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital 22-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3620 Echodale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter Costanza, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25 - 1940

8. AGE: Years	Months	Days	If less than one day
7	11	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Peter Costanza, Sr.

13. Birthplace Italy

MOTHER 14. Maiden Name Madalide Storto

15. Birthplace Md.

16 (a) Informant Mrs. Peter Costanza

(b) Address 3620 Echodale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director L. J. Luck

(b) Address 5305 Harford Rd-14

19 (a) JAN 16 1948 (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1948, at 2 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1948 to Jan 15 1948 and that I last saw him alive on Jan 15 1948

Immediate cause of death Acute Hemorrhage from rectum & stomach — Duration

Due to Acute Lymphoid Leukemia

Due to

Other Conditions Retroperitoneal Hemorrhage (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peter Costanza Jr

Address Univ. Hosp. Date signed 1-15/48 M. D.

Dr. Eisenberg
2025 E. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92a

G59112
Registered No. G59112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3117 Clearview Avenue
(c) Hospital or institution: 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3117 Clearview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Frank O. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Mary Annette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 7, 1894

8. AGE: Years	Months	Days	If less than one day
53	7	7	hr. min.

9. Birthplace: Burlington, Vermont
(Town, county, and state)
10. Usual Occupation: Custom House
11. Industry or business: Baltimore, Md.

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mrs. Mary A. Jones
(b) Address: 3117 Clearview Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Nat'l
Location: Baltimore, Md.

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road, 14

19 (a) JAN 16 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 19 48, at 1225 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945 to January 14, 1948, and that I last saw him alive on January 14, 1948.

Immediate cause of death	Duration
Cardiac Dilatation and Uremia	1 Day
Due to Aortic Insufficiency and Generalized Arteriosclerosis	3 Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Albert Eisenberg M. D.
Address 2025 E North Ave Date signed 1-14-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(59113 KOLASINSKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. 58113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL L4
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 S. Luzerne St
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Anthony Kolasinski

3 (b) If veteran, name war

(c) Social Security Account No. 212-14-3542

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maryanna Kolasinski

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 7 1865

8. AGE: Years 83 | Months 7 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name Peter Kolasinski
13. Birthplace Poland

MOTHER 14. Maiden Name Francis Kitos
15. Birthplace Poland

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location German Hill Rd

18 (a) Funeral director John J Duda
(b) Address 2829 Eldon St.

19 JAN 16 1948 (Date rec'd by registrar) (Signature) for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1948, at 8:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 1948
and that I last saw him alive on 1/13 1948.

Immediate cause of death: Coronary occlusion — Duration: 6 hrs.
Due to.....
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy: Post. myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Victor A. McKusick
Address Johns Hopkins Hosp. Date signed 1/14/48 M. D.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

59114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 59114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1934 W. Lexington St or P.O.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Lee Ashley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Walter L. Ashley

6 (c) If alien, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 7th 1877

8. AGE: Years 71 | Months 4 | Days 8 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jonas T. Crosbandon
13. Birthplace Va

MOTHER 14. Maiden Name Alice F. Lacey
15. Birthplace N. Y.

16 (a) Informant Walter L. Ashley
(b) Address 1934 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore, Md

18 (a) Funeral director J. B. Wippert Son
(b) Address 1300 Eutaw Place

19 (a) JAN 16 1948 (Date rec'd by registrar) Washington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1948 at 10:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive - Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. F. Schmidt M.D. Medical Examiner.
Date signed 1/16/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 55E

Registered No. G59115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 8-4
(b) Street address
(c) Hospital or institution: West Balto General Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2246 E. Hoffman St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Winters

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26th 1866

8. AGE: Years	Months	Days	If less than one day
82	4	20	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Winters
13. Birthplace Md

MOTHER
14. Maiden Name Estelle Ball
15. Birthplace Md

16 (a) Informant Mrs. A. Winters
(b) Address 2246 E. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20th 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave Ext

18 (a) Funeral director Leo S. Leach
(b) Address 1701-03 N. Patterson Park ave

19 (a) Jan 16 1948 (Date rec'd by registrar) (b) Registrar's signature Washington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15, 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31, 1947 to Jan 15, 1948, and that I last saw h[illegible] alive on Jan 15, 1948.

Immediate cause of death Intestinal Obstruction — Duration

Due to Diffuse Abdominal Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman Levin, M. D.
Address W. B. G. H. Date signed 1/15/48

X

59116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G58116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4409 Frederick avenue,
(c) Hospital or institution: 25-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Frederick ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BROTHER ALEXIUS, C.F.X. (MATTHIAS KEATING)

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1880

8. AGE: Years	Months	Days	If less than one day
67	8	10	hr. min.

9. Birthplace Rockchapel, County Cork Ireland (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name David Keating
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Connell
15. Birthplace Ireland

16 (a) Informant Brother Bartholomew, C.F.X.
(b) Address 4409 Frederick ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral directors Chas. P. Conroy Son Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) JAN 16 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Jan 15 1948, and that I last saw h[illegible] alive on Jan 12 1948.

Immediate cause of death Acute Cardiac Failure

Due to Myocardial Infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathaniel C. Keating

Address 215 W. Monument Date signed Jan 15/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G59117
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Catonsville
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 9
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1435 Gorsuch Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Margaret B. Connor ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1864

8. AGE: Years 83 | Months 5 | Days — | If less than one day: hr. min.

9. Birthplace Texas Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Patrick Connor
13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Fniarty
15. Birthplace Ireland.

16 (a) Informant Miss Isabel Connor
(b) Address 633 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/48 (month) (day) (year)
(c) Cemetery or crematory St. Josephs'
Location Texas, Maryland

18 (a) Funeral director H. H. Ffears and Son
(b) Address 805 N. Calvert Street

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16 1948, at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1947 to 1/16 1948 and that I last saw her alive on 1/14/1948

Immediate cause of death Cardiac failure — Duration
Coronary thrombosis
Senile Dementia
Due to Generalized arteriosclerosis
Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address St. Agnes Date signed 1/16/48

G59118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

G59118 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore - 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Foothill Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Sadie A Stuart

3 (b) If veteran, name war

3 (c) Social Security Account No. 338-12-1967

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	WHITE	WIDOW

6 (b) Name of husband or wife JOSEPH. E. STUART
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 6-1878

8. AGE: Years	Months	Days	If less than one day
69	7	9	hr. min.

9. Birthplace CHELSEA Mass. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business none

FATHER
12. Name JOHN G. CARTER
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name ELLEN GOSS
15. Birthplace UNKNOWN

16 (a) Informant CLARENCE W. STAPELTON
(b) Address 2819 Frederick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19 48 (month) (day) (year)
(c) Cemetery or crematory
Location LEOMINSTER MASS.

18 (a) Funeral director E. Haworth Conway
(b) Address 3911 Liberty Heights Ave
19 (a) JAN 16 1948 (Date rec'd by registrar) (b) Huntington Ave Mill Cemetery Mass Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 19 48, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 19 48, to 1-15 19 48 and that I last saw h[illegible] alive on 1-15 19 48

Immediate cause of death: Respiratory Failure — Duration

Due to Pneumonitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Fraher M. D.
Address 3 W. Lexington St Date signed 1-15-48

VS 189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

No. C59119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C59119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9Hrs. 10Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore - 20, - Rural (If outside city or town limits, write RURAL and give town)
Bowleys Quarters
(d) Street No. Box 163 A., Route 15, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christ

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/15/48
8. AGE: Years | Months | Days | If less than one day: 9 hr. 20 min.
9. Birthplace Balt. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard Francis Christ
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Marie Elizabeth Fitch
15. Birthplace Baltimore Md.

16 (a) Informant Richard F. Christ RFD
(b) Address Bowleys Quarters Box 163A
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore 3, Md.
18 (a) Funeral director John B. Moran
(b) Address 3060 E. Balto. Huntington Woods, Md.
19 (a) (Date received by Registrar) (b) Registrar

JAN 16 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16-48 19 6:30 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 PM 1-16-1948 to 6 AM 1-16-1948, and that I last saw h alive on 19

Immediate cause of death	Duration
Respiratory failure	
Due to paralysis	
Due to damage	
Due to Cerebral hemorrhage	3
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Lucas M. D.
Address Bon Secours Hosp. Date signed 1-16-48

659120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 659120

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Edwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 55 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALTIMORE Md Lawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 POPLAR DRIVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Mason Hammersla

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	white	WIDOWER

6 (b) Name of husband or wife: CECELIA HAMMERSLA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 28, 1869

8. AGE: Years	Months	Days	If less than one day
78	8	18	hr. min.

9. Birthplace FUNKSTOWN, MD. (Town, county, and state)
10. Usual Occupation BALTO. PATROL & WATCHMAN SER.
11. Industry or business

FATHER
12. Name FREDERICK HAMMERSLA.
13. Birthplace FUNKSTOWN, MD.

MOTHER
14. Maiden Name MARTHA OSBORNE
15. Birthplace MD.

16 (a) Informant MRS. ROBERT RIDGELY
(b) Address 2411 POPLAR DRIVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/19/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE CEM.
Location BALTIMORE MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address NORTH & PA. AVES.

19 (a) Filed Jan 16 1948 (b) Huntington Williams, M.D. Registrar
(Date to be filled in by registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1948, at 5 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1948 to Jan 16 1948 and that I last saw him alive on Jan 16 1948

Immediate cause of death	Duration
Pulmonary embolus	
Due to Arteriosclerotic Heart disease & Chronic congestive failure	
Due to Arteriosclerosis, generalized	
Other Conditions Diabetes mellitus Old myocardial infarct (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Weyeneth Jr.
Address Univ. Hosp. Date signed 1-16-48 M. D.

939

G59121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G59121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 ELLAMONT ST.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME FRANCIS EDWARD STROHMER

3 (b) If veteran, name war WW #1

3 (c) Social Security Account No. 207-20-7170

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife JOSEPHINE R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 16, 1895

8. AGE: Years	Months	Days	If less than one day
52	1	29	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation SALES MGR.

11. Industry or business ARLINGTON STROHMER

FATHER
12. Name HUDHOUSE STROHMER
13. Birthplace BALTO. MD

MOTHER
14. Maiden Name JENNIE MAY NEWCOMER
15. Birthplace BALTO. MD.

16 (a) Informant JOSEPHINE R. STROHMER-WIFE
(b) Address 2504 ELLAMONT ST.

17 (a) BURIAL (b) Date thereof 1/19/48
(Burial, cremation, or removal) (month), (day), (year)
(c) Cemetery or crematory BALTO. NATL.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address NORTH & FA. AVE. BALTO., MD

19 (a) JAN 16 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1948, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 1/15/48

G59122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Register G59122

Every item of information should be carefully supplied. The cause is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 West 30th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 West 30th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Fischer, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Johanna Fischer

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Dec 8, 1877

8. AGE: Years	Months	Days	If less than one day
70	1	6	hr. min.

9. Birthplace Germany.
(Town, county, and state)

10. Usual Occupation Life Ins.

11. Industry or business Lincoln Ins. Co.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Johanna Fischer
(b) Address 308 W 30th St.

17 (a) Burial (b) Date thereof Jan 10/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Cheshire & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) JAN 17 1948 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14/48 19..., at 10 A.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 1/14/48

S 151

C59123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered C59123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2329 Annapolis Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Annapolis Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Louise Sheckells

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John R.

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr) July 2, 1903

8. AGE: Years	Months	Days	If less than one day
44	6	12	hr. min.

9. Birthplace Kansas
(Town, county, and state)

10. Usual Occupation Advertising

11. Industry or business —

FATHER 12. Name Carl Fisch
13. Birthplace Germany

MOTHER 14. Maiden Name Rose Malchow
15. Birthplace Germany

16 (a) Informant John Sheckells
(b) Address 2329 Annapolis Rd

17 (a) Burial (b) Date thereof 1/17/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cems.
Location Frederick Ave

18 (a) Funeral director John F Kenny Inc
(b) Address 700 Eight St.

19 (a) JAN 17 1948 Clayton Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1948, at 11 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15, 1947 to Jan 14 1948, and that I last saw her alive on Jan 14 1948.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred Cole M. D.
Address 1934 Edgerton Ave Date signed 1-16-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59124 JL - 116336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59124

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 E. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Walter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1882

8. AGE: Years 65 | Months 8 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Bailey
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Jones
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 19 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) Date received 1-17-1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1948, at 5 Am M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1948, to Jan. 16 1948, and that I last saw her alive on Jan. 16 1948

	Duration
Immediate cause of death Probable, cerebral thrombosis	
Due to Arteriosclerosis, severe generalized	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vanlandingham M.D.
Address Balt. City Hosp. Date signed 1/16/48

VS 130

Baltimore City G59125

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G59125

SITAR CERTIFICATE OF DEATH 1948

Reg. Dist. No. .....

1. PLACE OF DEATH:

County .....

City or town Baltimore St

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, institution, or street address where death occurred: 4 52 E Curtis Ave

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A.A.

City or town Linthicum - Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. River Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Josephine Sitar

3.(b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widow

6.(b) Name of husband or wife John Sitar

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 11. 1880

8. AGE: Years	Months	Days	If less than one day
67	2	5	..... hrs. ..... min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual occupation None

11. Industry or business .....

FATHER 12. Name Unknown

13. Birthplace Austria

MOTHER 14. Maiden name Katherine Kirbely

15. Birthplace .....

16. Informant Mrs Katherine Andrae

Address 452 E Curtis Ave - 26

17. Holy Cross Date thereof 1/20-48 (month) (day) (year)

(Burial, cremation, or removal, which?)

Cemetery or crematory Holy Cross

Location Gov Ritchie Highway

18. Funeral director Milton Schulking

Address 3914 Hanover St Huntington Pottsville, Md

19. JAN 17 1948 (Date received by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1948, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 1947, to Jan 16 1948

and that I last saw h.. alive on Jan 16 1948

Immediate cause of death Cardio-Vascular Disease — DURATION 3 hrs.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas L. Bare Jr MD M. D. or other

Address Linthicum Date signed 1-16-48

C59126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered C59126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Central Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BECKHAM

3 (b) If veteran, name war

3 (c) Social Security Account No. 132--1-8823

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Ida M. Beckham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1908

8. AGE: Years	Months	Days	If less than one day
40	-	7	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Beckham
13. Birthplace S. C.

MOTHER
14. Maiden Name Sallie Fisher
15. Birthplace S. C.

16 (a) Informant Mrs. Eda M. Beckham
(b) Address Rockingham, N. C.

17 (a) Burial (b) Date thereof 1-20-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Hamlet, North Carolina

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 17 1948 (b) Lennington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 55

20. DATE OF DEATH January 14, 1948, at 6 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Fracture of Pelvis
(b) Fracture of Pelvis
(c)
Due to
Other Conditions Fract. of Pelvis -
Fract. of Pelvis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/14/48 3:45 P.M. 16/2
(b) Where did injury occur? Balto Co
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from Bed

23. Signature Carl L. Rogers M.D.
Medical Examiner
Date signed 15 Jan 48

VS 181

G59127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59127

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correctly and legibly. The correct age is especially important. Physicians: please write the exact causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Turners Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Finch Court. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAM THURMAN EDWARDS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Josephine Edwards

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1910

8. AGE: Years	Months	Days	If less than one day
37	8	8	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Enice Edwards
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Swanson
15. Birthplace Virginia

16 (a) Informant Annie Edwards
(b) Address 1013 First Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-19-48 (month) (day) (year)
(c) Cemetery or crematory
Location Lynchburg, Virginia

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman St.

19 (a) JAN 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1948, at 4.25 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-15-48 4 p. M.
(b) Where did injury occur? 411 Finch Ct. Turners Station, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms.

23. Signature Carl L. Boyle M.D. Medical Examiner.
Date signed 1-16-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered C59128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2827 Cold Spring Lane
(c) Hospital or institution: 15 W

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Smelkinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sophie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5. 1888

8. AGE: Years	Months	Days	If less than one day
59	11	11	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Merchant

FATHER
12. Name Isaac Smelkinson
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca Epstein
15. Birthplace Russia

16 (a) Informant Ralph Smelkinson
(b) Address 2827 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JAN 17 1948 (Date rec'd by registrar) (b) Huntington Wilkinson, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1948, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14, 1948 to 1/16, 1948, and that I last saw h[illegible] alive on 1/15, 1948.

Immediate cause of death Arteriosclerosis CVD — Duration 2

Due to —

Due to —

Other Conditions Cerebral Embolism — Four mos.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Swooman M. D.
Address 1109 N. Calvert Date signed 1/16/48

X

G59129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G59129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument
(c) Hospital or institution:
Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) over 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Montgomery
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4608 De Russey Parkway Chevy Chase
(If rural give location) Md
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olga Aaronson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Reuben

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Jacob Milwitzsky
13. Birthplace Russia

MOTHER
14. Maiden Name Hinda Mandelstam
15. Birthplace Russia

16 (a) Informant Dr Emanuel Aaronson
(b) Address 4608 De Russey Parkway

17 (a) Burial (b) Date thereof Jan 18, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JAN 17 1948 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1948, at 12:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1948 to 1/15 1948 and that I last saw her alive on 1/15 1948.

	Duration
Immediate cause of death: Hepatic insufficiency	5 mo
Due to: Pulmonary edema	5 hrs
Due to: Cirrhosis of Liver	5 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cirrhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rackoberg M.D.
M. D.
Address Sinai Hosp Date signed 1/15/48

VS 150

X

659130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 659130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2033 Orleans St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE HEINZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 27-1883

8. AGE: Years	Months	Days	If less than one day
65	8	18	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Chas H. Fiegin
13. Birthplace Balto

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mildred Peterson
(b) Address 3426 Louth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/48 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Frederick Ave

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St

19 JAN 17 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1948, at 7.30a M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Ryon M.D.
Medical Examiner

Date signed 1-15-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59131 Voss 1103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered 59131

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Williams Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lillian M. Voss

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife. Robert Voss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/1863

8. AGE: Years	Months	Days	If less than one day
82	10	10	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alexander White
13. Birthplace Balto.

MOTHER
14. Maiden Name Lucy
15. Birthplace Balto.

16 (a) Informant Family
(b) Address Same

17 (a) B. (b) Date thereof 1-17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Co.

18 (a) Funeral director J. L. McCauley
(b) Address 120 S. Front St. Baltimore, Md.

19 JAN 17 1948 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1948 at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 7 1948 to January 14 1948; and that I last saw [illegible] alive on January 14 1948

	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions Parkinson's Disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address 1 Pages Date signed 1/14/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G59132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Register G59132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reisterstown & Greene
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 714 N Caney St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Braxton Bessie Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Married

6 (b) Name of husband or wife Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1891

8. AGE: Years	Months	Days	If less than one day
56	11	14	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Elijah Kemp
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Emma Swan
15. Birthplace Frederick Co. Md.

16 (a) Informant Collins Gl. Stepfather.
(b) Address 714 N. Caney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1948, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1948 to 1/14 1948 and that I last saw her alive on 1/14 1948.

Immediate cause of death Cardiac failure

Due to Arteria sclerotic hypertensive cardio-

Due to vascular disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Taylor M. D.
Address Reisterstown & Greene Date signed 1/14/48

H H Taylor 1/15/48
X

659133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. 659133

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 Born Court
(c) Hospital or institution:
(d) Length of stay in hospital of inst. (yrs., mos., or days) W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Born Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13 [illegible]

8. AGE: Years	Months	Days	If less than one day
82	5	2	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation H. W

11. Industry or business

FATHER
12. Name James Cook
13. Birthplace Va

MOTHER
14. Maiden Name Lilly White
15. Birthplace Va

16 (a) Informant George Hawkins
(b) Address 702 Born Court

17 (a) Burial (b) Date thereof 1/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Balto Md

18 (a) Funeral director Isaiah L Brown Sons
(b) Address 1015 Monty omery Street

19 (a) JAN 17 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1948, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8/48 19 , to 1/15 1948, and that I last saw h. alive on 1/13/48 19

Immediate cause of death Myocardial Infarction

Due to Hypertensive Arteriosclerosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter T Cooper M. D.

Address 702 Edmondson Ave Date signed 1/17/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. C59134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4708 Falls Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas L. Hall

3 (b) If veteran, name war /

3 (c) Social Security Account No. 217-16-7971

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Sadie Hall

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 6-24-95

8. AGE: Years 52 | Months 6 | Days 21 | If less than one day ___ hr. ___ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Hall ?

13. Birthplace

MOTHER 14. Maiden Name Susan Mellon ?

15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-48 (month) (day) (year)

(c) Cemetery or crematory Pine Grove

Location Harford Co Md

18 (a) Funeral director Harmon A. Hemsley

(b) Address 678 W Biddle St

19 (a) JAN 17 1948 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15-1948, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3-1948 to 1-15-1948, and that I last saw h[illegible] alive on 1-15-1948.

Immediate cause of death Hemorrhage (Cerebral and Intestinal) — Duration

Due to Thrombocytopenia & liver failure

Due to Lymphatic Leukemia

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman Mellinkoff M. D.

Address Johns Hopkins Hosp. Date signed 1/16/48

X

G59135 JL - 116197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G59135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Talbot or Mary E. Talbott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1880

8. AGE: Years 67 | Months 1 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Amos Talbot
13. Birthplace Md.

MOTHER
14. Maiden Name Cornelia Turner
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Lee A. Stallone
(b) Address 163 West Mill Ave.

19 (a) 1-17-1948 (Give the 3 by number) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1948, at 5.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1947 to Jan. 15 1948, and that I last saw her alive on Jan. 15 1948

Immediate cause of death: Pulmonary edema
Diabetic acidosis — Duration 30 min.
Due to Diabetes mellitus — 36 hrs.
Due to Arteriosclerotic heart disease.
Other Conditions

(Include surgery within 3 months of death)
Date of operation Leg amputation 1-2-48
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp. Date signed 1-16-48

VS 150

G59136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G59136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Use correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 E. 26th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. HETTINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1913

8. AGE: Years 34 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name John E. Hettinger

13. Birthplace Germany

MOTHER 14. Maiden Name Gertrude Rasch

15. Birthplace Hungary

16 (a) Informant John C. Hettinger

(b) Address

17 (a) Burial (b) Date thereof 1/20/48 (month) (day) (year)
(burial, cremation, or removal)

(c) Cemetery or crematory Maryland Park

Location Balto Md.

18 (a) Funeral director William Cook Jones

(b) Address 1217 St Paul St.

19 (a) JAN 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1948, at 9 p. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1-16-48 at about 8 p. M.

(b) Where did injury occur? 607 -27th Street. Baltimore, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Firearms

23. Signature Carl L. Rogen M.D.
Medical Examiner.

Date signed 1-17-48

X

G59137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G59137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Wilmer Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY POLLARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
unknown	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	widowed

6 (b) Name of husband or wife unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace unknown
(Town, county, and state)
10. Usual Occupation unknown
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs. A. Read
(b) Address 528 N. Biddle St

17 (a) Burial (b) Date thereof 1-17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 (a) JAN 17 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1948, at 12.05 A M

21. I certify that I took charge of the remains described above, held an insp. & inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl A. Ruge M.D.
Medical Examiner.
Date signed 1-7-48

VS 181

BG59138 BC-48-00783 BALTIMORE CITY HEALTH DEPARTMENT Registered BG59138

CERTIFICATE OF DEATH

Reikenbacker 157-9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 Oakdale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Infant Boy Reikenbacker Baby Girl Reikenbacker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 14, 1948

8. AGE: Years	Months	Days	If less than one day
0	0	3	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Francis Clark Reikenbacker
13. Birthplace Maryland

MOTHER
14. Maiden Name Francis O'Donovan
15. Birthplace Maryland

16 (a) Informant Mrs. Peters
(b) Address Caton Ave

17 (a) Burial (b) Date thereof 1/17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Leakenmyer
(b) Address North Ave & Pa. Ave., Balto.

19 (a) JAN 17 1948 (b) [illegible] for William M. Mc[illegible]
(Date of registration) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1948 at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 17 1948 to Jan. 17 1948, and that I last saw ~~s~~ he alive on Jan. 17 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to Prematurity	
Due to Congenital Atresia G.I. tract	
Other Conditions Abd. operature Division	

(Include pregnancy within 3 months of death)
Date of operation 1-13-48
Major findings of operations Congenital Atresia G.I. tract
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. A. Langley M. D.
Address St. Agnes Hosp. Date signed 1-17-48

G59139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 WEBB Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1017 Webb Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Stull Kongsted

3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Nelson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 26. 1884
8. AGE: Years 63 Months 10 Days 22 If less than one day hr. min.
9. Birthplace Troy N. Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
12. Name of FATHER Henry Stoll
13. Birthplace Germany
14. Maiden Name of MOTHER Wehrmann
15 Birthplace Germany
16 (a) Informant Nelson Kongsted
(b) Address 1017 Webb Court
17 (a) Burial Cremation or removal (b) Date thereof 1/18/48 (month) (day) (year)
(c) Cemetery or crematory Elmwood
Location Troy N. Y.
18 (a) Funeral director Wilhelm & Doe
(b) Address 1215 Cont St
19 (a) JAN 17 1948 (Date rec'd by registrar) Burlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1948 at 3.20 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 19 to Jan 17 19 and that I last saw her alive on Jan 17 19

	Duration
Immediate cause of death: Acute Dilatation Heart	4 day
† Hypostatic Congestion Lungs	
Due to: Arterio Sclerosis †	yrs
Due to: Cerebral Hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry C Houck
Address 1221 W Mount Ave Date signed 1/17/48

VS 150

G59140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G59140

PLEASE WRITE PLAINLY, WITH INK AND ADVISE INK. Every question must be answered. Write the causes of death clearly and legibly. Give correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3561 Fourth Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Brooklyn, Baltimore 25 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3561 Fourth Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES E. HAWKINS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widower

6 (b) Name of husband or wife: Annie E. Hawkins Nee Farring
6 (c) If alive, give age: Deceased

7. Birth date of deceased (mo., day, yr.) June 5, 1858

8. AGE: Years	Months	Days	If less than one day
89	7	11	hr. min.

9. Birthplace: Anne Arundel County (Town, county, and state)
10. Usual Occupation: Retired Merchant
11. Industry or business: Grocery Store

FATHER
12. Name: William L. Hawkins
13. Birthplace: Anne Arundel County, Md.

MOTHER
14. Maiden Name: Leah S. Lee
15. Birthplace: Howard County, Md.

16 (a) Informant: George F. Hawkins
(b) Address: Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19, 48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Brooklyn, R.F.D.

18 (a) Funeral director: Thomas W. Singleton
(b) Address: Glen Burnie, Md.

19 (a) JAN 17 1948 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 19 48 at 7.07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 46 to Jan 19 48, and that I last saw h[illegible] alive on Jan 16 19 48

Immediate cause of death	Duration
Coronary occlusion	
Due to Hypertensive cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas W. Kenter M.D.
Address 302 Patapsco Ave Date signed Jan 16 48 M. D.

G59141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register No. G59141

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully scrutinized. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. Church Home & Hospital (If rural, give location) 1906 Pennsylvania Ave
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Georgiana Warfield

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27 1870

8. AGE: Years 78 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Calvert Co. (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Christopher Columbus
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace Maryland

16 (a) Informant Mrs. Agnes Duffield
(b) Address Church Home & Hosp.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/16/49 (month) (day) (year)
(c) Cemetery or ~~crematory~~ GREEN MOUNT CEM.
Location BALTIMORE, MD.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto., MD.

19 (a) JAN 17 1949 (Date rec'd by registrar) (b) Registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15/49 19 , at 8 1/2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/49 19 to 1/15 19 49. and that I last saw h alive on 1/15 19 49.

Immediate cause of death: Cerebral hemorrhage
Due to: Left hemiplegia
Due to: Arteria sclerotica cardio-vascular
Due to: Hypertensive disease
Other Conditions: Pulmonary infarct & thrombophlebitis
(Include pregnancy within 3 months of death)

	Duration

Date of operation
Major findings of operation:
of autopsy: See Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph D'Antonio
Address Church Home & Hosp. Date signed 1/16/49

659142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 659142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.S.A.
(b) Street address 1814 Poplar Grove St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Poplar Grove St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Carrie G Norris

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife MERLY M NORRIS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUL. 16, 1860

8. AGE: Years	Months	Days	If less than one day
87	6	8	hr. min.

9. Birthplace KINSAN, VA.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name JOHN GEMENY
13. Birthplace VA.

MOTHER
14. Maiden Name AMELIA BALLINGER
15. Birthplace Va.

16 (a) Informant MR. ANDREW GEMENY
(b) Address 4611 AMHERST RD., COLLEGE PK, MD

17 (a) REMOVAL (b) Date thereof 1/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CARMEL METH. CH. CEM.
Location KINSALE, VIRGINIA

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address NORTH & PA. AVES., BALTO., MD.

19 (a) JAN 17 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16 1948 at 1:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1/16/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be accurate. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G59143

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 46F

Reg. Dist. No.

G59143

PLACE OF DEATH:

City or town: Baltimore City 866 W Lombard St
(If outside city or town limits, write RURAL and give nearest town)

Long in above place of death? Baltimore

Hospital, institution, or street address where death occurred:

Long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rural Mt Airy Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

1. (a) FULL NAME Ira C Brown

3. (b) Social Security Number

Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

(b) Name of husband or wife: Mabel Brown

7. Date of birth (mo., day, yr.): June 24 1890 8.(c) If alive, give age: 25 years

Date of deceased (mo., day, yr.): 6/23/1890

AGE: Years	Months	Days	If less than one day: hrs.	min.
57	6	24		

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Well Drilling

Industry or business: Wells

12. Name of father: Owen C Brown

13. Birthplace: Md

14. Maiden name of mother: Sallie K Phillips

15. Birthplace: Md

Informant: Mabel V Brown

Address: Monrovia Md

Burial (Burial, cremation, or removal. Which?) Date buried: Jan 19 1948 (month) (day) (year)

Cemetery or crematory: Montgomery

Location: Capitol Hill Md

Funeral director: Boyd Barber

Address: Gaithersville Md

Jan 19 1948 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 Jan. 1948 at 12.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Jan. 1948 to 17 Jan. 1948 and that I last saw h[illegible] alive on 16 Jan. 1948

Immediate cause of death	DURATION
Carcinomatosis	unknown
Due to: Carcinoma of liver	unknown.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of liver Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charles Cummings M.D. M. D. or other

Address: 910 W. Lombard St. Date signed: Jan. 17-48.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere Aves
(c) Hospital or institution: Levindale Hebrew Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., moe., or days) 67 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Hebrew Home (If rural give location)
(e) Citizen of foreign country? / (Yes or No) If yes, name country

3 (a) FULL NAME Rose Silverstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10th 1879

8. AGE: Years: 68 | Months: 3 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: Not name on Known, Kramer
13. Birthplace: Russia

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Russia

16 (a) Informant: Mrs. Irene Hoffman
(b) Address 2104 Eagle Street Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-48 (month) (day) (year)
(c) Cemetery or crematory
Location: Herzl Mt Carmel

18 (a) Funeral director: Jack Levin Inc
(b) Address 2166 Eutaw Place

19 (a) (Date rec'd by registrar) (Functionary) Washington Williamson M.D.

JAN 20 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17th 1948 at 11 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15th 1948 to Jan 17th 1948 and that I last saw her alive on Jan 17th 1948.

Immediate cause of death	Duration
Acute heart failure	
Due to Hypertension & Jackson Epilepsy	
Due to possible brain tumor	
Other Conditions /	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Jerome J. Blumberg M. D.
Address Levindale Hebrew Home Date signed Jan 17th 1948

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G59145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 Morland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nathan Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Aaron

13. Birthplace Russia

MOTHER 14. Maiden Name Baila

15. Birthplace Russia

16 (a) Informant Ida Baker

(b) Address 1614 Morland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-48 (month) (day) (year)

(c) Cemetery or crematory Beth Tefloh

Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc

(b) Address 2106 Eutaw Place

19 (a) [illegible] (Signature of registrar) Registrar

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17 1948 at 12 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1948 to Jan 17 1948 and that I last saw h. alive on Jan 16 1948

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Cerebrovascular accident - myocardial infarction	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.

Address Sinai Hosp Date signed 1/17/48

107

G59146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

T-95B

G59146 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Lunacy
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince George
(c) City or town Baltimore Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 Main St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Leon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 28 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry Lehman
13. Birthplace Balto

MOTHER
14. Maiden Name Lillie
15. Birthplace Balto

16 (a) Informant Leon Ellis
(b) Address 337 Main St Laurel

17 (a) Burial (b) Date thereof 1-18-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Lot

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1948 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1948 to Jan 17 1948 and that I last saw her alive on Jan 17 1948

	Duration
Immediate cause of death Cardiorespiratory failure	
Due to Rheumatic Heart Disease	10 yrs
Due to	
Other Conditions Congestive Heart Failure (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard L Colen M. D.
Address Sinai Hosp of Balto Date signed 17 Jan 48

G59147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

G59147
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4428 Marble Hall Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Clay Hoover

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I & WW II	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1900

8. AGE: Years	Months	Days	If less than one day
47	10	10	hr. min.

9. Birthplace Webster Springs, W. Va.
(Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business --

FATHER
12. Name John Hoover
13. Birthplace Webster Springs, W. Va.

MOTHER
14. Maiden Name Saloma Alice McCray
15 Birthplace W. Va.

16 (a) Informant Records
(b) Address U.S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Hoover Cemetary
Location Webster Springs W. Va

18 (a) Funeral director Harry H. Lortzke
(b) Address 4101 Edmondson Ave

JAN 18 1948
19 (a) (b)
(Date rec'd by registrar) Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1948, at 11:26 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 9 48 to Jan. 16 1948, and that I last saw him alive on Jan. 16 1948.

Immediate cause of death acute myelogenous leukemia. — Duration unk.
Sec. cause: gas gangrene, generalized.
Due to
Other Conditions Old abscess, gluteal region.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joe M Chisolm M. D.
Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Age correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G5914 ✓ BALTIMORE CITY HEALTH DEPARTMENT G59148 Registered No. C5127

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md (b) County Baltimore
(c) City or town Riviera Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wendover Creek Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Miller
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1881

8. AGE: Years 66 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Henry Miller
13. Birthplace Germany.

MOTHER 14. Maiden Name Theresa Deeter
15. Birthplace Washington D.C.

16 (a) Informant Mrs Mary Miller
(b) Address Wendover Creek Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Road

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St - 25

19 (a) (Date rec'd by Registrar) (b) Registrar

Huntington Williams, M.D.

V.S. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1948 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Acute Cardiac Failure due to	
Acute Coronary occlusion	
Due to Hypertensive Cardio-	
vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. D. Coolidge M.D.
Address 1213 Light St Date signed 1/17/48

X

G59149 BC 48-002R BALTIMORE CITY HEALTH DEPARTMENT ✓ X G59149

CERTIFICATE OF DEATH 154B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & green
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 168 Wye & St. Georges Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Page

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/4/48

8. AGE: Years	Months	Days	If less than one day
0		14 days	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrew J. Page
13. Birthplace Md

MOTHER 14. Maiden Name Helen Smith
15. Birthplace Md

16 (a) Informant Andrew J. Page
(b) Address 168 Wye Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co

18 (a) Funeral director J. Brady Mish
(b) Address 4807 Eastern Ave Rd

19 (a) JAN 26 1948 (Date rec'd by Registrar) (b) Huntington Williams, MD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1948, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17, 1948, to Jan. 18 1948, and that I last saw him alive on Jan. 18 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Aspiration of vomitus	
Due to overwhelming toxemia; acidosis	
Other Conditions Osteomyelitis Lt mandible	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robt C. Hunter, M.D. M. D.
Address University Hosp. Date signed 1-18-48

VS 150

X

G59150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77c

Registered No. G59150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as correctly as possible. The correct age is especially important. Physicians: please write the exact causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 12-S
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 St. Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Swain

3 (b) If veteran, name war: W. W. #1

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Mary Swain

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 20 1895

8. AGE: Years: 52 | Months: 1 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Hagerstown Md
(Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business

FATHER
12. Name: Geo. W. Swain
13. Birthplace: Md.

MOTHER
14. Maiden Name: Jennie Kidwell
15. Birthplace: W. Va

16 (a) Informant: Mary A. Swain
(b) Address: 1416 Darley Ave

17 (a) Burial (b) Date thereof 1/21/48
(Burial, ~~cremation or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ U.S. National
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 Jan 1948, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute alcoholism

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Earl L. Royer M.D.
Medical Examiner
Date signed 19 Jan 48

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G59151 HEALTH DEPARTMENT—CITY OF BALTIMORE G59151

CERTIFICATE OF DEATH 1318

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1648 Normal Ave St. 8.5 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 66 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Ella Gertrude Bassett

If U. S. Veteran specify WAR

(a) Residence: No. 1648 Normal Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Whitmer Bassett

6. DATE OF BIRTH (month, day, year) July 9, 1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	6	8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. At Home

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME Thomas Leroy Barker

14. BIRTHPLACE (city or town) (State or country) Balto., Md.

MOTHER

15. MAIDEN NAME Mary Cecelia Barker

16. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

17. INFORMANT Daughter - Marie J. Bassett
(Address) 1648 Normal Ave

18. BURIAL, CREMATION, OR REMOVAL
Place Morland Park Date 1/20 19 48

19. UNDERTAKER William Cook Inc
(Address) 1217 St. Paul St.

20. FILED JAN 19 1948 19 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) January 17, 1948

22. I HEREBY CERTIFY, That I attended deceased from December 8, 1947, to January 17, 1948

I last saw her alive on January 16, 1948. Death is said to have occurred on the date stated above, at 11:20 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Bronchopneumonia Left	1947
Hypertensive Cardio-Vascular Disease	1946
Other contributory causes of importance: None	

Was an operation performed? No. Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No. If so, specify

(Signed) Hilton F. Cook M. D.

(Address) 42 vs Eastern Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Also state if DEATH was due to OCCUPATION. See instructions on back of certificate. OCCUPATION is very important.

VS 8

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G59152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Richmond
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MR. EARL L. COCHRANE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, or divorced Widowed

6 (b) Name of ~~husband or~~ wife Rose Cochrane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11th 1911

8. AGE: Years 36 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Technician

11. Industry or business Hospital

FATHER
12. Name Chas. F. Cochrane
13. Birthplace Mt. Airy, Md.

MOTHER
14. Maiden Name Pearl Dandy
15. Birthplace Balto. Md.

16 (a) Informant Dorothy Cochrane
(b) Address 1829 Eutaw Place

17 (a) Burial (b) Date thereof 1/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) 1-20-1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16-48 19 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15-48 19 to 1-16 19 48 and that I last saw h[illegible] alive on 1-16 19 48

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to DIABETIC COMA

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Manow Jr. M. D.
Address [illegible] Date signed 1-16-48

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G59153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 929

Register No. G59153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4401 Marblehall Road
(c) Hospital or institution: 27-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4401 Marble Hall Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Susan Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John H. Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1872

8. AGE: Years	Months	Days	If less than one day
75	10	0	hr. min.

9. Birthplace St. Mary's County, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Jefferson Issac Readmond
FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Susan Lumpkin of Virginia
MOTHER 15. Birthplace

16 (a) Informant John H. Harris
(b) Address Northwood Apt. 4401 Marblehall Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Jan 19 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1948, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1948 to Jan 17, 1948, and that I last saw her alive on Jan 7th, 1948

Immediate cause of death	Duration
Congestive Heart Failure	2 wks
Due to Arteriosclerotic Heart disease	2 yrs
Due to	
Other Conditions Bilateral bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick J. Vollmer M. D.
Address 6100 York Road Date signed Jan 17 1948

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G59154 — Registered G59154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 E Lombard St.
(c) Hospital or institution: 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 E Lombard (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Edgar Lee Parrish

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Margaret Parrish
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29th 1865

8. AGE: Years	Months	Days	If less than one day
82	7	18	hr. min.

9. Birthplace: Va (Town, county, and state)
10. Usual Occupation: Transfer Business
11. Industry or business

FATHER
12. Name: Robt Parrish
13. Birthplace: Va

MOTHER
14. Maiden Name: Dont know
15. Birthplace: Va

16 (a) Informant: Mrs Raymond Stark
(b) Address: 3217 Herbert Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20th (month) (day) (year)
(c) Cemetery or crematory: Parkwood Gem City
Location

18 (a) Funeral director: Ulrich Funeral Home
(b) Address: 2006 Orleans St.

19 JAN 19 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1948; at 6.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/16/1948 and that I last saw h[im] alive on 1/16/1948

Immediate cause of death: Art. Pulmonary Edema — Duration 12 hrs
Due to: Chronic Nephritis
Due to: Arteriosclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Wright L. Hadley
Address 3336 Balto Date signed 1/19/48

G59155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

G59155
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 N Duncan St
(c) Hospital or institution: Johns Hopkins Hospital 7.3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs. 35 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 N. Duncan Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert WARTHEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 3 - 1892

8. AGE: Years	Months	Days	If less than one day
55	9	11	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation Gen Laborer
11. Industry or business

FATHER
12. Name Henry R Warthen
13. Birthplace Md

MOTHER
14. Maiden Name Isabelle Galloway
15. Birthplace Md

16 (a) Informant Peter H. Bucheri
(b) Address 705 N Duncan St

17 (a) Burial (b) Date thereof Jan 19.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Allied Funeral Home
(b) Address 2006 Orleans St.

19 (a) JAN 19 1948 (b) Twining for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1948, at 11 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑; accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis
Pulmonary edema
~~Duo~~ Cirrhosis of liver
Acute alcoholism.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 1/15/48

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G59156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G59156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 936 Lemmon St.
(c) Hospital or institution: 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 936 Lemmon St. (If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No) If yes, name country ✓

3 (a) FULL NAME Nettie Kuhns

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Charles Kuhns

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug 1st 1889

8. AGE: Years 58 | Months 5 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Luray Va. (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name Adam Jenkins
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Mrs Catherine Beall
(b) Address 936 Lemmon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/48 (month) (day) (year)
(c) Cemetery or crematory Sinai Park Cem
Location 3801 Frederick Rd

18 (a) Funeral director John J. Sparwasser Son
(b) Address 901-03 Hollins St

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15th 1948, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947 to Jan 15 1948, and that I last saw h er/ alive on 10 Jan 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	1 mins.
Due to Arteriosclerosis	15 yrs
Due to Hypertension	15 yrs
Due to Diabetes Mellitus	15 yrs
Other Conditions Ventral Hernia	20 yrs

(Include pregnancy within 3 months of death)

Date of operation ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature H H Bayless M.D.
Address 600 Wilkens Ave Date signed 16 Jan 48

X

59157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 59157

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5914 Greenspring Ave.
(c) Hospital or institution:
none 27-20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5914 Greenspring Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve Thelin Hooper

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b). Name of husband or wife Ralph Hooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1889

8. AGE: Years	Months	Days	If less than one day
58	4	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William T. Thelin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Griswold
15. Birthplace Georgia

16 (a) Informant Elizabeth T. Hooper
(b) Address 5914 Greenspting Ave.

17 (a) Cremation (b) Date thereof 1/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ crematory Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1909 Eutaw Place

19 (a) JAN 19 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1948, at 4:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Jan 18 1948, and that I last saw h[illegible] alive on Jan 17 1948.

Immediate cause of death
Cerebral Hemorrhage Duration Gradual
Due to Large Bowel Obstruction
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1947 June
Major findings of operation: Confirmation by Biopsy
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Moody M. D.
Address 1403 Park Ave. Date signed 1-19-48

VS 150

C59158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. C59158

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3034 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARNOLD ARDUIN ORTMANN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1907

8. AGE: Years	Months	Days	If less than one day
40	4	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business Baltimore Public Schools

FATHER
12. Name Otto R. Ortmann
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret May Donoho
15. Birthplace Baltimore, Md.

16 (a) Informant Otto R. Ortmann
(b) Address 3034 St. Paul Street

17 (a) Burial (b) Date thereof 1/19/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 19 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1948 at 6.55 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Head, Fracture of Limb

Due to

Other Conditions Fracture of Pelvis.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-15-48 at 6 P. M. 4/1
(b) Where did injury occur? Lombard & Calvert St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by Balto. transit bus.

23. Signature Carl L. Kreyer M.D.
Medical Examiner.
Date signed 1-16-48

VS 181

X

G59159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 8-1
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Eutaw Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Roscoe German (ROSCOE BARTON GERMAN)

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of ~~husband~~ or wife Mrs. Gertrude German

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) June 12, 1882

8. AGE: Years 65 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Sales Manager

11. Industry or business Mens Wear Retailing

FATHER
12. Name Mr. Wm. German
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sarah Clarke
15. Birthplace Baltimore

16 (a) Informant THOMAS H. GERMAN
(b) Address RICHMOND, VA.

17 (a) Burial (b) Date thereof 7-19-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location BALTIMORE, MD.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JUL 19 1948 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16/48 19 , at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12/48 19 to 1/16/48 19 ; and that I last saw h. alive on 1/16/48 19 .

Immediate cause of death: Acute Failure Heart disease & Hypertension — Duration

Due to: Cardiac decompensation — Duration

Due to: Pulmonary edema. — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Church Home & Hosp. Date signed 1/16/48

G59160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Duke and or Rayner Ave
(c) Hospital or institution: West Baltimore Gen'l Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2415 Calverton Hgts.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME Frank Schwemmer.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	Yes 215-01-0367

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Md

6 (b) Name of husband or wife Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jun. 7, 1893

8. AGE: Years	Months	Days	If less than one day
54	7	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Vice Pres. & Secty.
11. Industry or business Montague & Rogers Inc.

FATHER
12. Name John Schwemmer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katie Waddock
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Grace Schwemmer
(b) Address 2415 Calverton Hgts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/48 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto., Md.

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1948, at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-18 1948 to 1-18 1948, and that I last saw h[illegible] alive on 1-18 1948.

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Acute Myocardial	
Due to IN Fraction	
Pulmonary Edema	
Due to Arterio Sclerotic	
Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [signature]
Address West Balt. Gen'l Hosp. Date signed 1-18-48 M. D.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C59161 / 1318 — Registered No. C59161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene Sts. 15.6
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3014 Presbury St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME Salvatore Salamone

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Pauline Salamone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1880

8. AGE: Years	Months	Days	If less than one day
67	1	22	hr. min.

9. Birthplace Sicily (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business --

FATHER
12. Name Rosario Salamone
13. Birthplace Italy

MOTHER
14. Maiden Name Jessie Savoca
15. Birthplace Italy

16 (a) Informant Dr. Louis Salamone
(b) Address 2400 Lauretta Ave.

17 (a) Burial (b) Date thereof 1/22/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto., Md.

19 (a) JAN 20 1948 (Date received by Registrar) Mary Lee Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1948, at 10 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1948 to Jan. 17 1948 and that I last saw him alive on Jan 17 1948

Immediate cause of death Acute Left Ventricular Failure
Due to pulmonary edema

Duration

Due to --

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Univ. Hosp. Date signed 1/17/48

VS 190

G59162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8312

Registered No. G59162

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Delaware Ave.
(c) Hospital or institution: --
27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4703 Delaware Ave.
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country --

3 (a) FULL NAME George Eberle

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Kate Virginia Eberle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business --

FATHER
12. Name George Eberle
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Roland G. Eberle
(b) Address 4703 Delaware Ave.

17 (a) Burial (b) Date thereof 1/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Fulton Aves. Balto., Md.

19 (a) JAN 19 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1948, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947, to Jan 1948, and that I last saw him alive on Jan 16 1948.

Immediate cause of death Heart Failure

Due to Cerebral Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
- one week

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury TOMPAKOV

23. Signature Samuel V. Tompakov M. D.
Address 3431 Park Heights Ave. Date signed Jan 19 48

G59163

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93c

Registered No. G59163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd
(c) Hospital or institution: 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city limits, write rural, and give town)
(d) Street No. 4515 Garrison Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha C. Ruppreckt

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Chas. G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1866

8. AGE: Years 81 | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business --

FATHER
12. Name ? Damaske
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant H. Henry Heilage Jr.
(b) Address 1604 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/48 (month) (day) (year)
(c) Cemetery or ~~xxxxxxx~~ Lorrraine
Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves; Balto., Md.

19 (a) Jan 19 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1948, at 2 45 M

21. I certify that I took charge of the remains described above, held an Inspector thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease.

Due to

Other Condition Arthritis, Chronic

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Hesselbrock M.D. Medical Examiner.
Date signed Jan 16, 1948

VS 151

G59164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. G59164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Cedarcroft Road
(c) Hospital or institution: 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 91 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Cedarcroft Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Leonard Gates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances Baker Gates
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) May 20 1856

8. AGE: Years	Months	Days	If less than one day
91	7	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Retired

FATHER
12. Name Frank Gates
13. Birthplace

MOTHER
14. Maiden Name Mary Hartzell
15. Birthplace

16 (a) Informant J. Nelson Gates (son)
(b) Address 705 Woodland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1948, at 8:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1946, to Jan. 16 1948, and that I last saw him alive on Jan. 16 1948.

Immediate cause of death: Coronary occlusion — Duration 3 hrs

Due to: Generalized arteriosclerosis — Duration 9 yrs

Due to:

Other Conditions: Chronic bronchitis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Frederick J. Boehmer, M. D.
Address 6100 York Road Date signed Jan. 19, 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 124a

Register C59165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.,
(c) Hospital or institution: Sinai Hospital 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3217 Vickers Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annette Agnes Seringer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Weston B. Seringer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1907

8. AGE: Years	Months	Days	If less than one day
40	6	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Gray
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ann Strumsky
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Weston B. Seringer
(b) Address 3217 Vickers Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) JAN 19 1948 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1948, at 7 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1948 to 1-18 1948, and that I last saw her alive on 1-18- 1948

Immediate cause of death	Duration
Acute liver decompensation	
Due to Laennec Cirrhosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard S Cohen M. D.
Address Sinai Hosp, Balto, Md Date signed 1-18-48

G59166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G59166 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Broadway
(c) Hospital or institution: Sinai Hospital 63
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 Mozer Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** IDA NESS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband ~~or wife~~ late George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
60 59			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Jacob Wolfe
13. Birthplace Russia

MOTHER
14. Maiden Name Rachel?
15. Birthplace Russia

16 (a) Informant Bessie Wolfe
(b) Address 295 Ann Street

17 (a) Burial (b) Date thereof 1 20 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mogan Abraham
Location Hamilton Ave. - Rosedale

18 (a) Funeral director Sol Leiner & Son
(b) Address 1124-26 W. North Ave.

19 (a) JAN 19 1948 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 199

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 1/18 19 48, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 19 48 to 1/18 1948, and that I last saw h.r alive on 1/18 19 48.

Immediate cause of death	Duration
Pneumonia	
Cardiac Decompensation	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Osman M Mears M. D.
Address Sinai Hosp Date signed 1/18/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G59167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 E. Oliver St.
(c) Hospital or institution: 8.7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 E Oliver St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: Annie E. Nelson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife John A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3 1873

8. AGE: Years	Months	Days	If less than one day
75	6 7	3	hr. min.

9. Birthplace Baltimore County (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name James H. Kramer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Theresia E Thorn
15. Birthplace Baltimore

16 (a) Informant Lillian Stanford
(b) Address 6722 Radnor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19 48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Duffel Bros
(b) Address 1800 E Fayette St.

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1948 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6/48 to 1/15/48 and that I last saw h alive on 1/15/48.

Immediate cause of death	Duration
Myocardial Degeneration	3 yrs
Due to Arteriosclerosis	5 yrs
Due to	
Other Conditions Hypertension Pneumonia	3 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Hergmann M.D.
Address 1710 E 33rd St Date signed 1/16/48

G59168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Register No. G59168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1161 W. HAMBURG ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1161 W. HAMBURG ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE ELLA WALL.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife THOMAS WALL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 1, 1872

8. AGE: Years 75 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace BALTO., MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business NONE

FATHER
12. Name JOHN SWARY
13. Birthplace W. Va.

MOTHER
14. Maiden Name ANNA KEYSER
15. Birthplace W. VA.

16 (a) Informant MYRTLE GARRISON
(b) Address 1112 BRENTWOOD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-19-48 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location FREDERICK AVE

18 (a) Funeral director Joseph T. Gaughan, Jr.
(b) Address 414 N. Franklintown Rd.

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17- 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1948 to Jan. 17, 1948, and that I last saw h[illegible] alive on Jan 17, 1948

Immediate cause of death	Duration
Acute Heart Failure	
Due to Acute Myocarditis	10 yrs.
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Louis J. Gleason M.D.
Address 876 Woodbourne Ave Date signed

VS 150

X 1 1/17/48

C59169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C58169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2605 Lewerlen Ave.
(c) Hospital or institution: No 8-13
(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Lewerlen Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Vogel

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 220-03-6306

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary E. Vogel.
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) December 15 1867

8. AGE: Years	Months	Days	If less than one day
80	1	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Shop. Meat
11. Industry or business Hochschied Kohn

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mary E. Vogel (wife)
(b) Address 2605 Lewerlen Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave

18 (a) Funeral director John L. Malley Sons
(b) Address 2434 E. Oliver St

19 (a) JAN 19 1948 (Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1947 to Jan 17 1948 and that I last saw h[illegible] alive on Jan 16 1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage	30 hrs
Due to Hypertension Arteriosclerosis	2 mo
(Decompensated) Heart	2 mo
Due to Colo Intestitinal Nephritis	2 mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. A. Stevens M. D.
Address 2918 Harford Rd Date signed 1-17-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G59170 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 Fait Ave.
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3430 Dillon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: PAUL M. BICHELL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christina Bichell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1901

8. AGE: Years 46 | Months 7 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Store-Keeper

11. Industry or business Confectionery

FATHER
12. Name Albert A. Bichell
13. Birthplace Maryland

MOTHER
14. Maiden Name Edith Emmart
15. Birthplace Maryland

16 (a) Informant Christina Bichell (Wife)
(b) Address 3430 Dillon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-48. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cemetery
Location 7401 German Hill Rd.

18 (a) Funeral director Charles S. Sailer.
(b) Address 901 S. Conkling St.

19 (a) 1-19-1948 (Received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1948 9:10PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Jan 15 1948, and that I last saw h[illegible] alive on Jan 15 1948.

Immediate cause of death	Duration
Acute Cardiac Failure.	
Due to Coronary Artery	
Due to Occlusion.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. C. Flemming for L. Ford. M. D.
Address 3503 Fait Date signed 1-16-48
For H. H. Davis, by
Howard J. Morgan, M. D.

4 copies

659171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered 659171

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 S Clinton St.
(c) Hospital or institution: Home 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S. Clinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Mary Bayer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William John

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Oct 23 1919

8. AGE: Years	Months	Days	If less than one day
28	2	24	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Jacob J. Maskell
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Barbara Miller
15. Birthplace Baltimore Md.

16 (a) Informant William J. Bayer
(b) Address 806 S. Clinton St.

17 (a) Burial (b) Date thereof 1/20/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cemetery
Location German Hill Rd.

18 (a) Funeral director John J. Doyle
(b) Address 2829 Hudson St.

19 (a) (b)
(Date rec'd by Local Registrar) Registrar

JAN 19 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1948, at 8:00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Jan. 1948 and that I last saw h[illegible] alive on Jan. 16 1948

Immediate cause of death	Duration
acute myocardial failure	2 days
Due to arterial Hypertension	15 Yrs.
Due to Interstitial Glomerular Nephritis	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeBoy
Address 601 S Ellwood Ave Date signed 1/16/48 M. D.

G59172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59172 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 Turnbridge Rd
(c) Hospital or institution: 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 Turnbridge Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Schuchhardt

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Mary E. Schuchhardt
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 29, 1863
8. AGE: Years 84 | Months 2 | Days 19 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Proprietor
11. Industry or business Hardware Store

FATHER
12. Name Conrad Schuchhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Mahrenholz
15. Birthplace Germany

16 (a) Informant Mr. Frederick Schuchhardt
(b) Address 3/0 Turnbridge Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location E. North Ave. E. of Loudon Ave
18 (a) Funeral director Edwin W. Coulbourn Son
(b) Address 724 E. Eager St.
19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1948, at 2:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 1/18 1948, and that I last saw him alive on 1/17 1948.

Immediate cause of death: Arteriosclerotic heart disease — Duration: Years

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Henry M. Hamm M. D.
Address 20 E. Cromwell St. Date signed 1/19/48

VS 150

G59173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G59173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 N. Mount St.
(c) Hospital or institution: 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Kenney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1885

8. AGE: Years: 62 | Months: 6 | Days: 29 | If less than one day: hr. min.

9. Birthplace Macon N. C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Robert Kenney
13. Birthplace N. C.

MOTHER
14. Maiden Name Virginia Miller
15. Birthplace N. C.

16 (a) Informant Ruth Neal
(b) Address 1573 W. Lafayette Ave.

17 (a) Burial (b) Date thereof 1-19-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 19 1948 (b) Katie R. Williams
(Date rec'd by registrar) (Signature of Funeral Director)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1948, at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Jan 14 1948 and that I last saw h[illegible] alive on Jan 14 1948.

	Duration
Immediate cause of death (a) Coronary thrombosis	
Due to (b) Left hemiplegia	1 mo.
Due to (c) Hypertension	15 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Geo. H. Mumford M. D.
Address 1723 Druid Hill Ave. Date signed 1-16-48

VS 150

X Cancer

G59174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G59174

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Brookwood Lunch Rm. Frederick Road
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Jones Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Butts

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Black	married

6 (b) Name of husband or wife Ida M. Butts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10, 1881

8. AGE: Years	Months	Days	If less than one day
66	3	5	hr. min.

9. Birthplace Howard County, Md.
(Town, county, and State)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William H. Butts
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Louise Walker
15. Birthplace Howard Co. Md.

16 (a) Informant Ida M. Butts
(b) Address 10 Jones Ave. Catonsville Md.

17 (a) Burial (b) Date thereof Jan. 19, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star
Location

18 (a) Funeral director Mrs. Peter R. Williams
(b) Address 322 N. Schroeder St

19 (a) JAN 19 1948 Huntington Williams, Registrar
(Date received by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Jan 1948, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 15 Jan. 48

G59175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G59175 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7-4
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FREDERICK Houston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Anna Houston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 17, 1909.

8. AGE: Years 38 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name William Houston.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lottie Jackson.
15. Birthplace Baltimore Md.

16 (a) Informant Lottie Houston.
(b) Address 1421 Ward St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) JAN 19 1948 (Date rec'd by registrar) Tunstall Williams, Registrar

MEDICAL CERTIFICATION 55

20. DATE OF DEATH January 15, 1948, at 11 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrell M.D. Medical Examiner.
Date signed 1-15-48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G59176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3210 Montebello Terrace
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Montebello Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph F. Hoeflich

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Katherine Schwemm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1874

8. AGE: Years	Months	Days	If less than one day
73	11	6	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business P. H. Volk

FATHER
12. Name Frederick
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Gable
15. Birthplace Germany

16 (a) Informant Mrs. Charles Currey
(b) Address 3210 Montebello Terrace

17 (a) Burial (b) Date thereof 1/19/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) Jan 19 1948 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15th 1948, at 9 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1946 to Jan 15th 1948, and that I last saw h[illegible] alive on Jan 14th 1948.

Immediate cause of death	Duration
Carcinoma of Prostate	2 years
Due to	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation June 1946
Major findings of operation: Carcinoma of Prostate
Autopsy? No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work?
(Specify type of place)
(e) Means of injury None
23. Signature L. L. Gordy M.D.
Address 5106 Harford Rd Date signed 1/16/48

G59177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G59177

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2420 E. Lanvale St
(c) Hospital or institution:
82
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 E Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Maude Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wade H. Wheeler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 23 - 1883

8. AGE: Years: 64 | Months: 2 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Joseph G. Beaver

13. Birthplace: Balto. Md

MOTHER 14. Maiden Name: Ella B. Walker

15. Birthplace: Balto Md

16 (a) Informant: Maude E. Wheeler

(b) Address: 2420 E Lanvale St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1 - 20 - 48 (month) (day) (year)

(c) Cemetery or crematory: Baltimore

Location: North Ave

18 (a) Funeral director: H. H. Mellvaine

(b) Address: 2435 E Oliver St

19 (a) JAN 19 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 17 - 1948 at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Jan. 17 1948 and that I last saw h[illegible] alive on Jan. 15 1948

Immediate cause of death: Hypertensive cardio-vascular disease — Duration: 5 yrs

Due to: — Duration: yrs

Due to: — Duration: yrs

Other Conditions: parotid tumor — Duration: 10 yrs?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edmund Moore M.D.
Address 3165 Belair Rd Date signed 1-18-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G59178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1426 Wilmore Ct
(c) Hospital or institution: 14-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Wilmore Ct
(If rural give location)
(e) Citizen of foreign country? WHITE (Yes or No) V
If yes, name country

3 (a) FULL NAME Martha Turner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Chas.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/4/1896

8. AGE: Years 57 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Wm Summers
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Sarah Bozzle
(b) Address 1424 Wilmore Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Huntington Williamson, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1948 at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1948 to 1-15 1948 and that I last saw h— alive on 1-14 1948.

Immediate cause of death Acute Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration
5 Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. J. Fletcher
Address 1725 Edmondson Date signed 1/19/48

G59179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G59179 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 127
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 Howard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MONEY / McDONEL LYONS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1887

8. AGE: Years	Months	Days	If less than one day
60	7	29	hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Robinson
13. Birthplace Georgia

MOTHER
14. Maiden Name Sarah Richarson
15. Birthplace Georgia

16 (a) Informant Clara Johnson
(b) Address 1102 Fulton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-48 (month) (day) (year)
(c) Cemetery or crematory Athens Ga.
Location Ga.

18 (a) Funeral director George E. Kelson
(b) Address 1343 Pennsylvania Ave

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH January 14, 1948, at 8:20 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions Hypertrophy of heart. Scarring of kidneys.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George H. Merrill M.D. Medical Examiner.
Date signed 1-15-48

83a

G59180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G59180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.U.A.
(c) Hospital or institution: Johns Hopkins Hospital 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Alicanna St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — —

3 (a) FULL NAME Frank Leonard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married (now Widower)

6 (b) Name of husband or wife Marie (now Benzis)
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 8-14-1885

8. AGE: Years	Months	Days	If less than one day
(63) 62	4	29	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Transit Co.

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Maria Leonard
(b) Address 1909 Alicanna St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 (a) JAN 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17 1945 at 4:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Sulenski M.D. Medical Examiner.
Date signed 1/17/45

X

G59181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G59181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33d.
(e) Length of stay in Baltimore (yrs., mos., or days) 58yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALTIMORE, MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 BENNETT RD (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) **FULL NAME** LAWSON, HELEN M.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN 7 1890

8. AGE: Years	Months	Days	If less than one day
58	0	10	___ hr. ___ min.

9. Birthplace BALTO., MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business Home

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant: Arthur Lawson
(b) Address 102 Bennett Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) JAN 20 1948 (Date rec'd by registrar) (b) —

Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 17 1948 at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1947 to 1/17 1948, and that I last saw her alive on 1/17 1948.

Immediate cause of death	Duration
PULMONARY INFARCT	
Due to EMBOLISM	
Due to	
Other Conditions POST-OP ATRESIA, COMMON BILE DUCT	

(Include pregnancy within 3 months of death)

Date of operation 12/23/47
Major findings of operation: ATRESIA, COMMON BILE DUCT
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry P. Baltz M. D.
Address St. Joseph's Hosp Date signed 1/19/48

G59182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G59182
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Catherine Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Heisner (John Heisner)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-16-5371

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Antonia Kaisler

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 1-1-73

8. AGE: Years 75 | Months 0 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Weighty

11. Industry or business

FATHER 12. Name William Heisner

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Bard

15. Birthplace Germany

16 (a) Informant Daughter Mrs. Catherine Stevens

(b) Address Catherine Ave, Green Haven Anne Arundel Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Annapolis Blvd., Anne Arundel Co. Md

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 (a) 1948 (b) Huntington Williams, M.D. Registrar
Rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17 1948, at 8:22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1948 to 1-17 1948 and that I last saw h[illegible] alive on 1-17 1948.

Immediate cause of death: ASCVD

Due to: Coronary

Due to: Pneumonia

Other Conditions: Bronchial Asthma, Hypertension

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M.D.

Address Mercy Date signed 1-21 48

G59183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G59183 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 1612 Carswell Street
(c) Hospital or institution: 91
(d) Length of stay in hospital or inst. (yrs., mos., or days): None
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: City
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1612 Carswell Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Howard G.Bishop

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: 218-18-7156

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Hilda R.Taylor
6 (c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): May 29th., 1885

8. AGE: Years: 63 | Months: 7 | Days: 18 | If less than one day: ######## hr. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Painter
11. Industry or business: House-Painter

FATHER
12. Name: John F.Bishop
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Virginia Lighthouser
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs.Hilda R.Bishop (Wife)
(b) Address: 1612 Carswell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-20-48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Frederick Road, Balto: Md.

18 (a) Funeral director: George J.Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) ____ (b) ____ (Date rec'd by registrar) ____ Registrar

JAN 19 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17th., 1948, at 7-50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-1 1948 to Jan 17 1948, and that I last saw h... alive on Jan 17 1948.

Immediate cause of death	Duration
Acute Coronary Thrombosis	1 day
Due to: Cerebro-Sclerosis	2 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: E. Gill Hall M. D.
Address: 1631 E. North ave Date signed: 1/19/48

X

G59184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G59184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3321 Beech Ave.
(c) Hospital or institution: 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3321 Beech Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry M. Carper.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary J. Carper

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1873

8. AGE: Years: 74 | Months: 10 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: Elevator Operator

11. Industry or business: Social Security Board

MOTHER / FATHER

12. Name: Stewart Carper

13. Birthplace: Virginia

14. Maiden Name: Alberta Grim

15. Birthplace: Virginia

16 (a) Informant: Mary J. Carper.

(b) Address 3321 Beech Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19/48 (month) (day) (year)

(c) Cemetery or crematory: Weathon

Location: Edgewood Post Office

18 (a) Funeral director: Chenowith & Donovan

(b) Address 3615-17 Chestnut Ave

19 (a) (Date received by registrar) (b) Huntington Wells (Registrar)

JAN 19 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1948, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1947 to Jan 15 1948, and that I last saw him alive on January 15 1948.

	Duration
Immediate cause of death: Myocardial Insufficiency	24 hrs
Due to: Arteriosclerosis	
Due to: Cardiac Pain	8 yrs
Other Conditions: —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature A. M. Smith M. D.

Address 3429 Chestnut Ave. Date signed 1/16/48

vs-15

G59185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G59185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave.
(c) Hospital or institution: St Agnes Hospital 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 S Monroe St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Jesse J. Ulrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Edna Ulrich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 12, 1889

8. AGE: Years	Months	Days	If less than one day
58	2	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Japanner
11. Industry or business

FATHER
12. Name John Ulrich
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Davis
15. Birthplace Delaware

16 (a) Informant Mrs John Ulrich
(b) Address 312 S Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN. 21 '48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Harry H Wiltze
(b) Address 4101 Edmondson Ave

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17/ 1948 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/ 1948 to 1/17 1948, and that I last saw him alive on 1/17 1948.

Immediate cause of death	Duration
Congestive failure	
Due to Coronary Occlusion	11 days
Due to	
Other Conditions Diabetes mellitus	?

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Hubert J Lemke
Address St Agnes Hosp. Date signed 1/19/48

94a

G59186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓55E

Registered No. G59186

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St 9-6
(c) Hospital or institution: South Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1847 E 30th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George C. Hunt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1892

8. AGE: Years	Months	Days	If less than one day
55	0	21	hr. min.

9. Birthplace Canada (Town, county, and state)
10. Usual Occupation Caretaker
11. Industry or business Russell D Zilley

FATHER
12. Name George C Hunt
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Ella Pettaton
15. Birthplace U. S.

16 (a) Informant Russell D Zilley
(b) Address 1847 E 30th St

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Jan. 21 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry A Wiltze
(b) Address 4101 Edmondson Ave

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Certificate from Williamsville, Ill.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18/1948, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1947 to Jan 18 1948. and that I last saw h[illegible] alive on Jan 18 1948

Immediate cause of death: Respiratory failure — Duration

Due to: Squamous cell Adenocarcinoma of neck

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. D Coopher
Address 1213 Light St Date signed 1/19/48 M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

059187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered 059187

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4906 Kenwood Ave
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Raspeburh, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4906 Kenwood Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TERESA BARBARA BECKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Henry Becker
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1891

8. AGE: Years	Months	Days	If less than one day
56	6	20	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Buettner
13. Birthplace Germany

MOTHER
14. Maiden Name Kate Hallbach
15. Birthplace Germany

16 (a) Informant Mr. Henry Becker
(b) Address 515 N. Marlyn Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Road

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1948, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14 1948 to 1-18 1948, and that I last saw h alive on 1-18 1948.

Immediate cause of death	Duration
Myocardial infarction	5 days
Due to Coronary thrombosis	5 days
Due to —	
Other Conditions Pleural effusion	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address Union Memorial Hosp Date signed 1-18-48 M. D.

VS 150

C59188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C59188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2522 Wilkens Ave.
(c) Hospital or institution: 20-5
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Decker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry A. Decker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22 1868

8. AGE: Years	Months	Days	If less than one day
79	9	27	hr. min.

9. Birthplace Prince Georges Co Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Bernard Buscher
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Henry A. Decker
(b) Address 2522 Wilkens Ave

17 (a) Burial (b) Date thereof Jan 21 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry F. Tennant
(b) Address 4204 Ridgewood Ave.

19 (a) JAN 19 1948 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1948, at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Jan 18 1948, and that I last saw her alive on Jan 18 1948.

Immediate cause of death	Duration
Pulmonary Oedema	
Due to Hypertension,	
Due to Hemiplegia	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Bertsch M. D.
Address 215 W Wilkens Ave Date signed 1/19/48

VS 150

1937

G59189

BALTIMORE CITY HEALTH DEPARTMENT

Smelser CERTIFICATE OF DEATH 61

Registered No. G59189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 2884 Parkwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Burton B. Smelser

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-10 3977

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence Smelser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1902

8. AGE: Years 45 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Dairyman

11. Industry or business Western Md. Dairy

FATHER
12. Name DAIRD B. SMELSER
13. Birthplace MARYLAND

MOTHER
14. Maiden Name Clara Schaffer
15. Birthplace Maryland.

16 (a) Informant Mrs. Florence Smelser
(b) Address 2884 Parkwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto., Md.

18 (a) Funeral director Wm. H. Tickner & Sons
(b) Address North & Pa. Ave. Balto. Md.

19 (a) JAN 19 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18-48 1948 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1948 to 1-18 1948, and that I last saw h[illegible] alive on 1-18 1948

Immediate cause of death: Pulmonary Embolism — Duration: 6 Hours

Due to: diabetic gangrene of Left foot

Due to: infection & uncontrolled diabetes

Other Conditions: Hypertrophy of prostate & Mild arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard B. Preston, M.D.
Address Md. Gen. Hosp. Date signed 1-18-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59190

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No. G59190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Linthicum Heights
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Catalpa Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles B Garwood

3 (b) If veteran, name war —
3 (c) Social Security Account No. 214-18-3151

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife Myrtle C. Garwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) — 8/2/1869

8. AGE: Years	Months	Days	If less than one day
78	5	15	hr. min.

9. Birthplace Connecticut (Town, county and state)
10. Usual Occupation Executive
11. Industry or business Glass Foundry

FATHER
12. Name Joseph Garwood
13. Birthplace New Jersey

MOTHER
14. Maiden Name Sarah Brown
15. Birthplace New Jersey

16 (a) Informant Patient
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/21/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Pleasant Cem.
Location Millville, N. J.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) JAN 19 1948 (Date filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17 1948 at 11 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1948 to 1-17 1948 and that I last saw h. alive on 1-17 1948.

Immediate cause of death Pulmonary Embolus — Duration

Due to Phlebothrombosis of leg veins — Duration

Due to arteriosclerotic C-V Disease — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Workman M. D.
Address Univ. Hosp. Date signed 1-18-48

G59191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162H

Registered No. G59191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Mercy Hospital 13-2 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2032 Brookfield Avenue
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME LLOYD A. STALEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War # 2	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 1905

8. AGE: Years	Months	Days	If less than one day
42	7		..... hr. ..... min.

9. Birthplace Washington Co. Penna.
(Town, county, and state)
10. Usual Occupation Construction Worker
11. Industry or business

FATHER
12. Name Warren Staley
13. Birthplace Long Island, N. Y.

MOTHER
14. Maiden Name Florance Nathaway
15. Birthplace Penna.

16 (a) Informant Fleming Funeral Home
(b) Address Cochranton, Penna.

17 (a) Removal (b) Date thereof Jan. 19, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cochranton, Penna.
Location Cochranton, Penna.

18 (a) Funeral director William Cook, Inc.,
(b) Address 1217 St. Paul Street

19 (a) Jan 19 1948 (Date rec'd by registrar) (b) Lucretia Williams Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17, 1948, at 11.10 A. M.

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation, due to illuminating-gas,
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-17-48 at ? 10 a. M.
(b) Where did injury occur? 2032 Brookfield Av. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stove gas burners on, unlit

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1-17-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered G59192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D. of A
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days) 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4219 Lasalle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick C. Bienstein or (Beinstein)

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-7663

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Clara Eleanor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16-1878

8. AGE: Years	Months	Days	If less than one day
69	11	0	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business P.R.R.

FATHER
12. Name Charles Bienstein
13. Birthplace ✓

MOTHER
14. Maiden Name Anna Eitel
15. Birthplace Md.

16 (a) Informant Miss Louise Bienstein
(b) Address 4219 La Salle Ave.

17 (a) Burial (b) Date thereof 1/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director J. J. Luck
(b) Address 5305 Harford Rd.

19 (a) JAN 19 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17 1948 at 12:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lalumia M.D.
Medical Examiner.
Date signed 1/17/48

VS 151

G59193 Lilienfeld
714 E. Preston St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G59193 Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1235 E. Lanvale Street
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1235 East Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE M. BIEMILLER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Edward W. Biemiller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1873

8. AGE: Years	Months	Days	If less than one day
74	8	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name J. Adam Sohl
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Kauder
15. Birthplace Baltimore

16 (a) Informant Mr. Louis S. Biemiller
(b) Address 1235 E. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 JAN 19 1948 (Date rec'd by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1948, at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1947 to Jan 17 1948 and that I last saw h[illegible] alive on Jan 16 1948

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Lilienfeld M. D.
Address 714 E. Preston Date signed Jan 17

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C59194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Register No. C59194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 635 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LAVANIA BAYTOP

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-25-1883

8. AGE: Years 64 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace St. Marys Co, Md. (town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name Rafe Butler

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name unknown

MOTHER 15. Birthplace

16 (a) Informant Jacob A. Baytop

(b) Address 635 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna. Ave.

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Huntingtown, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1948, at 6.38 M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions Ventral hernia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L Ryan M.D. (Medical Examiner.)

Date signed 1-16-48

X

G59195

A 5-985-8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 157

Registered No. G59195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town Greenock. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Milton Sollers, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-28-47

8. AGE: Years	Months	Days	If less than one day
		20	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Milton Sollers
13. Birthplace Md

MOTHER
14. Maiden Name Virginia Wells
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20 48 (month) (day) (year)
(c) Cemetery or crematory Walkers Lgem
Location Drum Md

18 (a) Funeral director H. A. Saudenstricker
(b) Address Catonsville Md.

19 JAN 19 1948 (Date received by registrar) (b) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 17 - 1948 at 3 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5- 1948 to 1-17- 1948 and that I last saw h[illegible] alive on 1-17- 1948.

Immediate cause of death	Duration
cardio-respiratory failure	
Due to Congenital cerebral defect	20 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Crigler, Jr. M.D.
Address The Johns Hopkins Hosp. Date signed 1-17-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

59196 #5122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. 59196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town Plum Point Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Bessie Brooks

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife John Brooks (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-83

8. AGE: Years	Months	Days	If less than one day
64 63	9	3	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER 12. Name George Green
13. Birthplace Md.

MOTHER 14. Maiden Name Martha E Ward
15. Birthplace Va.

16 (a) Informant Johns Hopkins Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-48 (month) (day) (year)
(c) Cemetery or crematory Plum Point
Location Calvert Co

18 (a) Funeral director P. C. Lovell
(b) Address Prince Frederick Md

19 (a) 1-9-1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1948 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8 1947 to Jan. 18 1948 and that I last saw her alive on Jan. 18 1948.

Immediate cause of death	Duration
Gastrointestinal Hemorrhage	
Due to Uremia	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation 12/30/47
Major findings of operation: Carcinoma of bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. W. Mitchell Jr. M.D.
Address Johns Hopkins Hospital Date signed 1/12/48

G59197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered G59197

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 ROLAND AVE.
(c) Hospital or institution: KIRKLEIGH VILLA. 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 YEAR
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 ROLAND AVE (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME: KATHERINE McELWEE.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---------

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) June 16, 1855

8. AGE: Years	Months	Days	If less than one day
92	7	2	..m.m..hr. ..m.m..min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business ---------

FATHER
12. Name William McElwee
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Gillispie
15. Birthplace Ireland

16 (a) Informant Katherine B. McElwee
(b) Address 4301 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director W. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JANY 18 1948 19 at 3.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JANY 21 1947 to JANY 18 1948 and that I last saw her alive on JANY 18 1948

Immediate cause of death	Duration
CHRONIC MYOCARDITIS JANY 21	1947
Due to ARTERIOR SCLEROSIS	1947
Due to	
Other Conditions NONE	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward P. Lawrence M.D.
Address 3013 ST PAUL STREET Date signed JANUARY 18 1948

G59198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G59198 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1817 W Pratt st
(c) Hospital or institution 1944

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 W Pratt st (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Grace Ludwig

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 188[illegible]

8. AGE: Years 67 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Benjamin Love
13. Birthplace England

MOTHER
14. Maiden Name Adelia Edmonson
15. Birthplace Not known

16 (a) Informant William Ludwig
(b) Address 1817 W Pratt st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Co Md

18 (a) Funeral director Guy C Fraley
(b) Address Fulton Ave Baltimore

19 (a) JAN 19 1948 (Date rec'd by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1946 to Jan 7 1948 and that I last saw h.e.r alive on Jan 16 1948

Immediate cause of death Coronary thrombosis — Duration 2 yr.
Due to Coronary Hypertension — 1 yr.
Due to Hypertension Heart disease.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Thos Ludwig Jr. M. D.
Address 1933 W Balt St Date signed 1/19/48

VS 150

G59199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

G59199 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 146 N. Exeter St
(c) Hospital or institution: S-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 146 N. Exeter St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Byrd

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Albert Byrd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Mississippi (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Charles Reed

13. Birthplace Miss.

MOTHER 14. Maiden Name Unknown

15 Birthplace "

16 (a) Informant Anna M. Byrd

(b) Address 146 N. Exeter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Elroy Cathleen

18 (a) Funeral director 1000 Druid Park

(b) Address

19 (a) JAN 19 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1948 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6 1947 to 19, and that I last saw h[illegible] alive on Jan 13 1948

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Pulmonary Edema	
Due to Pneumonia	
Other Conditions Obesity - Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry A. Fine M. D.

Address 11 S. Bisquit St. Date signed 1/16/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G59200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

195E

G59200
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Monongalia
(c) City or town Morgantown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Childs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1926

8. AGE: Years	Months	Days	If less than one day
21	3	9	hr. min.

9. Birthplace Monongalia, West Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business B. & O. Railroad Co.

FATHER
12. Name Ray Childs
13. Birthplace West. Virginia

MOTHER
14. Maiden Name Opal White
15. Birthplace West Virginia

16 (a) Informant Daring's Funeral Home
(b) Address Morgantown, West Virginia

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 1/19/48 (month) (day) (year)
(c) Cemetery or crematory Morgantown
Location Morgantown, West Virginia

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) 1-19-1948 (Date rec'd by Registrar) (b) Arrington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Jan 19 48, at 3 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Complete fracture of pelvis & intrapelvic hemorrhage

Due to

Other Conditions Fract. Sternum & Fract of left ankle
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1-18-48 at 3 A.M.
(b) Where did injury occur? Found Holiday St. South Bath St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found on curb

23. Signature Medical Examiner. M.D.
Date signed 19 Jan 48

4/1

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8-30 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 55951 AND ENDING WITH 59200 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne

END OF REEL